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CLINICAL LECTURE.

TWO CASES OF ABDOMINAL CANCER.¹

BY PROFESSOR S. JACCOUD,
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Gentlemen: The study of two patients now present in our wards will enable me to direct your attention to the double obligation which the diagnosis of abdominal cancers entails, and to the great difficulties attending such diagnosis. The double obligation which I assign to the diagnosis belongs to all tumors: it is necessary to determine the *seat-topographic diagnosis*; and it is equally necessary to indicate the *nature-nosologic diagnosis*. The application, then, of this principle to abdominal cancers is but a particular case of a general rule; but it is perhaps in cancers of the abdomen that this application meets with the greatest difficulties.

It may happen that in the same patient the two parts of the diagnosis are equally easy or equally obscure; and it may also happen that one of the parts of the diagnosis is evident, while the other is entangled in very serious difficulties. This is the case with our two patients; in one of them, the patient who occupies No. 7 of Ward Jenner, the topographic diagnosis is so plain that there is little chance for mistake, while the nosological diagnosis remains almost doubtful; on the other hand, in the patient who occupies No. 28 of the same ward, the nosological diagnosis can be affirmed at first sight, while the topographic diagnosis continues to be obscure, if not uncertain.

Let us now enter into the detail of the facts. Our patient of No. 7 is a man 58 years old, a currier by occupation, who entered the hospital June 22, twelve days ago, because he had been for some time suffering with pains in the abdomen. He says, moreover, that he has grown somewhat thin, but does not complain of any alteration in his general health; the appetite is good, the digestion perfect, there is neither diarrhoea nor constipation. It is possible that he may have lost flesh, but he is still in sufficiently good condition; his features are animated, he is rather florid in the face, and there is nothing in this man to awaken the idea of a grave affection, much less of a cachectic disease. Proceeding to the examination of the abdomen to find the cause of the pains from which he is suffering, I detect at once by the sight, before making any palpation, a large swelling occupying all the region above the umbilicus, extending from one hypochondrium to the other. In the vertical direction the abnormal protuberance is seen to reach from the point of the xiphoid appendix to a finger's breadth above the umbilicus; there a deep fissure clearly separates it from the inferior region of the abdomen. This voluminous tumor strictly follows the respiratory movements, moving in its entirety during both inspiration and expiration, thus conforming itself to the rise and fall of the diaphragm.

Already to simple inspection this swelling, by reason of its volume and its configuration, gives the idea of a hard production; and, in fact, on palpation, the tumor is found to be everywhere of a compact hardness, this induration being almost uniform at all points. I say almost, for to be strictly exact I should add that it may in

¹Delivered in the Hôpital Pitié, Paris, France.

this respect be divided into two parts, the one right, the other left; the right part is a little more bulging, and a little harder than the other. To percussion the tumor is absolutely and uniformly dull in all its extent; this dulness is continuous, without any line of demarcation, with that of the liver, whose upper limit does not seem to be displaced.

To sum up: there is a voluminous supra-umbilical tumor, obeying the movements of the diaphragm, not separable from the liver, presenting under exaggerated dimensions the form of this organ—such is the result of our investigations. The topographic conclusion is then plain enough; we have to do with a tumor of the liver. This conclusion is confirmed by the presence of a venous network, very highly developed over the abdominal wall; this network, which has been observed to augment rapidly during the days which have followed the entrance of the patient, is quite like that which is seen in advanced cirrhosis. The spleen is normal, the lungs and the heart intact. At the lower part of the left pleura certain light friction-sounds are heard; these are physical signs due to contiguity, which throw no light on the nature of the tumor: the latter has caused some perihepatitis, whence come the pains experienced by the patient; and, by spreading, the inflammation has gained the pleura and has produced a limited amount of dry pleurisy.

We come now to the nosologic diagnosis. What is the nature of this tumor of the liver? To answer this question, we get no hints from the pleural rubbing sounds, nor from the development of the subcutaneous network of veins; can we find any elements for a right judgment of the case in the physical characters of the tumor? Yes, doubtless; but here, if we are not careful, we shall be led astray, for the signs may deceive us. By the definiteness of its contour, by its regular convex bulging, this tumor immediately suggests the notion of a hydatid cyst. This first impression is corroborated by the absence in the patient of all digestive disorder, of all cachectic symptoms. We have really in this case, as much from a local point of view as from that of the general condition of the patient, the normal and typical picture of a huge echinococcus cyst; and I should certainly have halted at this diagnosis, which I believe to be wrong, if I had not followed the rule which I have for many years adopted in cases of this kind. Before pronouncing a positive opinion, and while still dwelling upon

the resemblance of the tumor to a hydatid cyst, I have examined the inguinal region; I have found in Scarpa's triangle the glands on both sides augmented in volume, and greatly indurated. Upon this discovery, the absolute importance of which an experience many times repeated has taught me, I have at once rectified my judgment and formulated the diagnosis of cancer of the liver.

This is sufficient to indicate the importance which I attach to the state of the lymphatic glands in the nosologic diagnosis of abdominal tumors; and it is above all to the glands of the groin that attention should be given on such occasions. Last year, my colleague Troisier called attention to the alteration of the cervical and supra-clavicular glands in cancer of the stomach, and more generally, in abdominal cancers. This alteration is important, without doubt; but, in my experience, it is less frequent and more tardy than that of the inguinal glands. I have often, indeed, observed the differences which are easily noticed in the present patient; the inguinal Pleiades are completely and powerfully affected, while in the neck we can barely find on the left side a single gland that is plainly indurated; this gland, however, is not at all swollen, for its volume does not exceed that of a lentil. In many other cases also I have noted a more or less pronounced alteration of the glands of the groin, when a minute examination revealed the perfect integrity of the cleido-cervical glands. I maintain then the preponderant importance of the alteration of the inguinal glands as a sign of abdominal cancer, whether of the stomach or of any other of the viscera.

I will improve this occasion to correct anew a mistake in semeiology which has been committed with relation to the induration of the cervical glands in the course of pulmonary lesions. Chomel, and especially Grisolle, have each maintained that in these conditions the ganglionic induration is a certain sign of cancer of the lung. This proposition is too absolute; a long time ago, in my "Clinic of the Charity," I proved that this alteration may be linked to tuberculous lesions.

Since the entrance of the present patient till to-day, *i.e.*, for nearly a fortnight, we have not observed in him any change other than a rapid enlargement of the subcutaneous venous network of the abdomen; so that to-day, as at the beginning, my diagnosis is founded solely on the alteration of the glands of the groin. If this diagnosis is ultimately

confirmed, our observation will prove once more the semeiological value of these glandular indurations; if it shall prove to have been wrong, the signification of these lesions will be seriously shaken. To speak truly, I have no great anxiety on this score, for thus far this sign has never led me into error. I shall have finished with this first patient when I have indicated the number of the red blood corpuscles; this is 3,545,000, a number below the normal, doubtless, but which does not indicate a cachectic state.

The other patient is a shoemaker, 62 years old, who came to us five days after the preceding, on June 27. He occupies bed No. 28, Ward Jenner. He also suffers with a trouble in his abdomen, and it is not difficult to tell why; this man, in fact, is so emaciated, his complexion is so wan, without at the same time being straw pale, that the moment we knew that the seat of his disease was in the abdomen, we were at once certain that his disease was abdominal cancer.

I examine, and I find the confirmation of the nosologic diagnosis in the lymphatic glands; two groups are involved, but in very different degrees. In the inguinal regions all the glands are voluminous and indurated, and, moreover, perfectly painless. In the left side of the neck two glands are taken, between the two heads of the sternomastoid muscle; the upper is not augmented in volume, while the lower is as large as the end of the thumb, is very hard, and dips into the thorax by its inferior extremity.

In accordance with all these facts, and taking due account of the general alteration of the inguinal glands, I am certain that the intermediary glands are equally affected, whether in the mesentery, mediastinum, or in both regions at once. Keep this statement in mind, for we shall certainly have occasion before long to verify it. The blood dyscrasia is more marked than in the other patient, the number of the corpuscles being 2,385,100; but the profound cachexia would lead us to suppose a much more considerable diminution.

This patient, then, is certainly affected with an abdominal cancer; there is no chance for doubt. But where is the seat of this cancer? The topographic diagnosis meets here a real difficulty. For a long time this man has suffered with pain in his abdomen; but the pains have been vague, diffuse, without precise localization; as for pressure, it is not more painful over one spot than over another; these symptoms cannot enlighten me. What have been the other symptoms?

Besides the emaciation and the enfeeblement, which cannot give much information, there is only one marked symptom, constipation, which has twice been so obstinate that his medical attendants feared intestinal occlusion. On the first occasion, the constipation lasted seven days. A brisk purgative was given on the eighth day, after many similar cathartic doses had been previously administered, and triumphed over the obstruction. The second period of obstruction was much more grave. It was not only by reason of the absence of stools that the attending physician inferred occlusion of the intestine, but also because this phenomenon coincided with rapid tympanitic distention of the belly, with a sharp exacerbation of the pains, and especially with the occurrence of nausea; it does not appear that there was vomiting. In this situation, the physician who attended this man in town naturally thought of the urgent necessity of an operation, and had him admitted into one of the surgical wards of this hospital. The repeated administration of energetic purgatives restored the normal stools, after which the patient was transferred to my service.

I have told you all the symptoms observed; are they sufficiently significant to reveal the seat of the lesion? Assuredly not. The first idea which they suggest is that of cancer of the intestine; and this idea is chiefly supported by the facts of obstruction twice noticed. But when a cancer causes sufficient stricture of the intestine to give rise to symptoms of occlusion, even temporarily, alternate periods of constipation and diarrhoea are observed in the course of the disease; moreover, the stools are bloody, or else glairy or muco-purulent. Now, all these symptoms are wanting, as we are assured by the daily examination of the fecal matters. On the other hand, in the supposed conditions of an intestinal cancer producing occlusion, palpation as a rule gives positive results when we take pains to examine specially the regions which are the seat of election of this tumor. These regions are, the rectum, the iliac fossæ, the loins, and the sub-umbilical part of the abdomen. But in this patient, these investigations most carefully practised are quite barren of results; the abdomen in its entirety is a little prominent, but in the regions indicated nothing is found—absolutely nothing.

I reject, then, the diagnosis of a localization of the cancer in the intestines; and, without allowing myself to be led astray by

the numerous lacunæ and symptomatic anomalies which seem to condemn this judgment, I believe that we have to do here with a case of cancer of the stomach, and I shall now search for the proof of this supposition in an attentive investigation of the epigastric region.

I note also that it is only in this region that we find anything abnormal; sonorosity to percussion is not complete; there is a shade of dulness, not only in the epigastrium, but also as far as the umbilicus. Over this region, especially midway in it, I feel a little too much resistance; this resistance is uniform, without projection or tumor. In consequence of these observations, I believe that there is a diffuse cancer of the anterior wall of the stomach, although the characteristic symptoms of this affection have thus far been completely wanting.

This diagnosis, I hardly need tell you, does not explain the accidents of intestinal obstruction; but, by reason of the extension of the dulness and resistance as far as the umbilicus, I think that the omentum is involved. It may be, also, that the mesenteric glands participate in the alteration, as I told you when calling your attention to the glands of the groin, and of the two cervical glands. Consequently, I refer the temporary intestinal occlusion to the compression exercised by certain peritoneal or glandular productions, and not to a lesion of the intestine itself. The bringing together of these two cases for purposes of comparison, seems to me to have a real utility, for it illustrates the serious difficulties which may attend both the nosologic diagnosis and the topographic diagnosis of abdominal cancers. It teaches us, besides, the means which we have at our disposal for triumphing over these difficulties, which I ought to tell you cannot always be surmounted.

The second of these patients will certainly succumb in the near future, and in his case, at least, we shall have an opportunity for verifying the exactness of the diagnosis which I have been led to make.

The patient died one month after the foregoing conference. The diagnosis was confirmed before his death by the development of certain very important additional symptoms, viz.: pain on pressure in the epigastric region; frequent vomitings, which were not bloody; and a well-marked jaundice, without appreciable modification of the liver itself. The icterus, accompanied by jaundiced urine and pale stools, was evidently due to compression of the bile-

ducts by gastric or perigastric tumors. At a subsequent lecture, Dr. Jaccoud said:

The autopsy, only the principal particulars of which I shall here give in accordance with notes made by M. Duflocq, has revealed the following lesions: Cancer of the lesser curvature of the stomach and of the pylorus; mechanical obliteration by compression of the common bile-duct; retention of bile in the gall-bladder and in the liver; general invasion of the glands. The mesentery forms a block of cancerous nodules of various sizes. The glands of the lesser curvature of the stomach, and the prevertebral and pelvic glands are greatly swollen, and so are the inguinal, bronchial, and cervical glands. The intestine is sound throughout its whole length; the great omentum is intact. The spleen is diminutive. With the exception of the lesion of the omentum, which we expected to find and did not find, the diagnosis was verified in all its parts.

The nosologic diagnosis in the case of the first patient, founded solely on the alteration of the glands, has been also confirmed. The following note from M. Bourcy will inform you of the clinical phenomena which were developed after the last lecture, as well as the results of the autopsy.

During the month of July, the general condition remained quite good. In only the last days of the month the appetite diminished, then failed altogether; emaciation came on, there was every evening a little edema about the ankles; in a word, the first symptoms of a cachexia of which the progress was thenceforth extremely rapid. In August, there were on two occasions abundant coffee-ground vomitings. From that time, the patient took almost no food, and the emaciation became extreme. The edema of the legs was permanent; it spread to the thighs, the scrotum, the abdominal wall, and was accompanied with ascites. The excessive dropsical enlargement of the inferior members and of the abdomen presented a most striking contrast with the emaciation of the trunk, the arms, and the face. From that time, it was no longer possible to examine the deep abdominal viscera.

The inguinal glands remained to the end tumefied to the same degree as they were at the entrance of the patient; but the left cervical gland grew rapidly, and at the end of September it had attained the size of a large nut. In September, the cachexia became more and more pronounced, eschars formed on the sacrum, and the patient

succumbed on the morning of the 30th, after several days in which he was in a semi-comatose state.

The autopsy revealed the following alterations. On opening the abdomen, a considerable quantity of ascitic liquid escaped; the liver was found occupying all the epigastric region, completely covering the stomach, and literally stuffed with yellowish cancerous nodules of variable size; it was, therefore, the cancerous liver that formed the epigastric tumor felt during life. The determination of the primary centre of the cancer was quite easy. The stomach presented around the pylorus a sort of cancerous collar deeply excavated by jagged and sanguous ulcerations, with conservation of the pyloric lumen. Here was the primary focus of the cancer, from which were disseminated by the absorbents numerous secondary nodules:

1. In the liver, which, augmented in size but not deformed, without large superficial and salient projections, was infiltrated with innumerable nodules; the latter were isolated in places, confluent in others, of volume varying between a hemp-seed and a chestnut, of a yellowish-white color, and trenching sharply on the substance of the liver, which was reduced to small dimensions.
2. In the glands of the hilum of the liver, which made strong pressure on the vena portæ, causing the ascites.
3. In the head of the pancreas.
4. On the inferior aspect of the diaphragm.
5. In the tracheobronchial glands.
6. In one of the cervical glands on the left side.

The lungs, the heart, the liver, the kidneys, the intestine, the genital organs, presented no secondary nodules.

—Dr. Wilhelm Zimmermann, of Greifswald, has been appointed Assistant in Anatomy in the University of Berlin, as successor to Dr. Klaatsch, who is to go to Jena.

—The enterprise and progressive spirit of Japanese surgeons may be inferred from the fact that the *Sei-I-Kwai* medical journal, August, 1888, contains a paper on "Three Successful Cases of Extirpation of Ovarian Dermoid Cysts," and one on the "Use of Cocain in Laparotomy for Extra-Uterine Pregnancy of 14 Months." So far as we know, this makes only the second case in which an abdominal section has been made with cocaine as a local anaesthetic. The first was reported by Dr. Roswell Park, in the *Medical Press of Western New York*, August, 1888.

COMMUNICATIONS.

HEMORRHOIDS AND THEIR TREATMENT.¹

BY G. H. KIRWAN, M.D.,
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The subject assigned for to-day's paper and discussion is one of such importance to practical physicians and surgeons that it might wisely have been assigned to some older and abler member than I; but, appreciating the honor you conferred in selecting me, I have done with the subject the best that, with a very limited practical experience, I could, viz.—given you in what follows a compilation from some of the best authorities, and a *résumé* of some of the different recent methods of treatment, together with a comparison of the results obtained from each; and finally, have drawn conclusions therefrom.

Hemorrhoids, hemorrhoidal tumors, or the hemorrhoidal disease are medical terms used to define a diseased condition of the lower extremity of the rectum: the morbid condition that exists is almost always a dilatation or varicosity of the blood vessels; but these changes vary, according to the kind of hemorrhoidal tumor present, and will be described in defining the different varieties. Hemorrhoids are classified as *internal* and *external*, according as they are within or without the external anal sphincter. Such a division, however, is a merely arbitrary one. Of the so-called external hemorrhoid there are two varieties: the one a mere cutaneous teat or tab of redundant tissue so often observed about the margin of the anus; this variety, which is painless, may be present for years without giving any trouble, and is frequently simply the remains of the second variety after absorption has taken place; the second variety is a tense, bluish, smooth tumor due to dilatation alone, or to dilatation and subsequent extravasation of venous blood.

A more scientific classification of hemorrhoids, however, is one based upon the pathological changes that have led to their production. Considering them from this standpoint we have of internal hemorrhoids three distinct varieties, viz.: the Capillary, the Arterial, and the Venous hemorrhoid. The capillary hemorrhoid is really an erectile tumor (though never very large), composed of the terminal branches of the arteries and veins and the capillaries that unite them.

¹ Read before the meeting of the Luzerne Co. Pa. Medical Society, September, 1888.

It strongly resembles an ordinary small arterial nævus, and bleeds upon the slightest touch, hemorrhage being the chief symptom which distinguishes this variety. When it exists, hemorrhage always follows defecation, and this is the form ordinarily known as bleeding pile.

The arterial hemorrhoid is composed of a mass of freely anastomosing, tortuous, and varicose arteries and veins, bound together by connective tissue. The veins may be dilated into sacs or pouches, and the artery which enters at the base is of large calibre. Such a hemorrhoidal tumor is of large size and smooth surface, and is liable to inflammation, hemorrhage, and prolapse.

The venous hemorrhoidal tumor consists entirely at first of a simple varicose condition of the large veins beneath the mucous membrane of the rectum; later the veins undergo degenerative changes until a large, bluish, hard tumor is formed, which always comes out of the anus on defecation and assumes, from repeated exposure, a cutaneous character.

All the best authorities insist that these three varieties of internal hemorrhoids are well marked, and may exist at the same time, but they must be distinguished from each other in treatment.

The ordinary symptoms of internal hemorrhoids are a feeling of weight or fulness with a throbbing sensation in the rectum—in fact, a continual consciousness (not observed in health) that one has a rectum and anus, and that something is the matter with them. Bleeding upon defecation, and in some cases for a little time after it, is another symptom, not, however, constant in all cases. Other symptoms are: constipation; a feeling of weight and heaviness about the parts; a frequent desire to go to stool, with the belief that a full and free movement of the bowels will take place and relieve the sensation of uneasiness; and lastly, a protrusion of the hemorrhoidal tumors through the anal sphincter.

The feeling of weight and uneasiness hardly ever amounts to pain; if there is severe pain, it will usually be found after dilatation that a fissure or ulcer exists as a complication. When the hemorrhoidal tumors come down and are caught in the grip of the sphincter, there will be, of course, quite severe pain, which is immediately relieved by replacing the tumors within the bowel.

I have gone thus lightly and rapidly over the definition, varieties, pathology, and symptoms in order to devote most of my

space to what I take it should be the principal part of all papers read before this Society, namely, treatment.

On the medical treatment of hemorrhoidal tumors or the hemorrhoidal disease, but a few words are necessary, as perhaps no case of well-developed internal hemorrhoidal disease has ever been cured by medical treatment alone, and but very few are even benefited by it, except temporarily. If hemorrhoids depend on congested or diseased conditions of the liver, or upon obstruction to the portal circulation from any cause, the relief of this condition by appropriate treatment will materially benefit the hemorrhoidal disease. In the relief of obstinate constipation, special attention should be given to the state of the bowels; the recumbent position should be assumed at stool; unstimulating food and, if addicted to its use, complete abstinence from alcohol should be advised. Locally, some astringent ointments or suppositories, and the injection into the rectum of very cold, even iced, water may be employed. These are about the usual remedies, but any or all of them as a rule frequently fail even to relieve, and, I repeat, rarely if ever effect a cure in advanced internal hemorrhoidal disease.

In coming now to the most important part of our subject, the surgical treatment of hemorrhoidal tumors for their radical cure, I have selected for consideration, from the dozen or more surgical procedures suggested and practiced, only four, viz.: 1. The Injection Method, sometimes called Kelsey's. 2. The Clamp and Cautery Method, called Smith's. 3. Mr. Whitehead's Operation. 4. The Ligature Method, with incision, Mr. Allingham's.

The injection method is performed as follows: An enema of hot water having been used and the patient having forced down the tumors into view as much as possible by straining, about five drops of a fifteen, thirty-three, or even fifty per cent. solution of pure carbolic acid is injected into the substance of the largest of the tumors. After this the tumor is replaced within the bowel. If by the second day after this injection no pain or soreness exists, a second tumor is similarly dealt with, and so on till all are treated.

Dr. Charles B. Kelsey, of New York, whose name is intimately connected with the treatment of hemorrhoids by injection, has materially modified his views as to the effectiveness of this method in all cases since the publication by him in 1885 of 200

cases treated in this way. He says in the latest edition of his work on Hemorrhoids, "that he has since had pain, marginal abscess, ulceration and fistula follow its use," and that "the treatment by injection may not result in a radical cure." He further says: "In a word, the question narrows itself down to this: on the one hand we have a method safe, certain, and practically painless (the clamp and cautery method), but which involves the administration of ether and the performance of what the patient dreads—a surgical operation and a certain confinement to the house for a few days; on the other hand, a method which involves fully as much of an operation as the other, only more quickly performed, and without ether, and which is neither radical nor certain in its results." And he further says: "All the patient actually gains in the most favorable case is the avoidance of a safe operation, which he fears, to submit to an uncertain one, which he does not fear because of his ignorance."

Dr. Bodenhamer, of New York, an eminent specialist, says: "Never having treated a case of hemorrhoids by the injection method, I have therefore no experimental knowledge of it; but of its bad sequelæ I have abundant experience and proof, having since 1875 treated thirty-five cases of patients who had submitted to this operation, but who were not only not cured but much injured in various ways by it. The most of these cases had anal abscesses and anal fistulæ to follow it; others had anal fissure to result from it; others again had a thickening and induration of the coats of the lower portion of the anal canal, which interfered greatly with the normal action of the external sphincter. In some of the cases the operation was followed by extensive sloughing of the cellular membrane in the vicinity of the tumors, and by persistent hemorrhage, and others have had hard nodules follow the treatment. In all these cases, as far as I could learn, carbolic acid in different degrees of strength was the agent which had been used. In 1875 I made the following remarks in the New York *Medical Record*: 'The method of treating hemorrhoidal tumors by injecting them with coagulant hemostatic and cicatrizing solutions is of quite recent date. From the great excitement recently manifested by a few fanatics concerning this method, some were inclined to raise the cry "*eureka*," or led to believe that it, like Aaron's rod, was destined to swallow up all other methods. It may be remarked, however, with regard to this new candidate for

fame, that as yet it has no status in surgery, and it is questionable whether it ever will prove a real benefit to, or an advancement in, that science as it regards a safe and certain remedy in the treatment of hemorrhoids especially.'

Mr. Allingham says of this method of treatment: "I have tried the injection plan in many cases. The result was generally much pain; more inflammation than was desirable; a lengthy treatment; and the result doubtful—*certainly not a radical cure.*" And again: "All attempts to destroy vascular growths by causing coagulation of blood or inflammation in them while they are not shut off from the general circulation *must be fraught with danger*. You can have no guarantee that the coagulum may not break down and minute particles of dead tissue find their way into the vascular or lymphatic systems and result in embolism, or pyæmia, or both."

The clamp and cautery method is a well-known form of treatment which has many eminent advocates. The name of Mr. Henry Smith, of London, is most frequently associated with it. "In its performance each pile is seized by a volsellum and drawn well down. The clamp is then applied so as to embrace its base; the portion above the clamp is cut off with scissors, and the stump cauterized, usually with a Paquelin instrument." Mr. Allingham says of this operation: "In my opinion it has little to recommend it: as regards danger to life (after all, the issue of the *greatest moment*), as far as my most careful researches have led to a conclusion, it is quite six times as fatal as the ligature properly and dexterously applied; there are, moreover, these disadvantages: the burning causes very great pain after the operation, especially if the skin is involved; secondly, hemorrhage is more likely to occur than after the best mode of operating, greater sloughing of the parts takes place, and a longer period is required for healing."

Dr. Kelsey, of New York, gives as his views a directly opposite opinion; he says: "I prefer the clamp and cautery to all other radical measures, as being less painful and giving a quicker recovery."

Mr. Whitehead's operation is a plastic operation for the radical cure of hemorrhoids of recent date, it being little more than a year ago that its originator, Mr. Walter Whitehead, of London, first called attention to it. It is performed as follows: The pile-bearing mucous membrane is dissected off from the skin border of the anus

all around, after the manner of performing total extirpation of the rectum (except, of course, more superficially), and all the pile-bearing area removed. All bleeding vessels are twisted, and the mucous membrane above the pile-bearing surface is brought down and stitched to the skin border. Dr. Robert F. Weir, of N. Y., has performed this operation for hemorrhoids many times, and I believe gives it his preference in all suitable cases. Mr. Whitehead himself claims many points of advantage for it over all other surgical procedures, but those generally conceded are that the hemorrhage is trifling, the union is primary, and retention of urine very rare. For those who prefer the very latest in the surgical treatment of hemorrhoids, this operation is here given.

The *Pittsburgh Medical Review*, in a late comment upon Mr. Whitehead's operation and Dr. Weir's method of performing it, says: "It is certainly a much more surgical method than the old ligature operation, but to all appearances offers no special advantages beyond the satisfaction it affords the surgeon in performing a plastic operation, and freedom from subsequent retention of urine." Mr. Allingham's objections to this operation are that it is in most cases a more formidable undertaking than the existing condition warrants; that the length of time required for the operation, and the excessive hemorrhage as compared to the ligature method, make it inferior to other methods in most cases.

We come now to the consideration of what I believe from a careful study of this disease is the operation for the radical cure of hemorrhoidal tumors; although, of course, it will be understood that no one method can be applicable to all cases. *Exempli gratia*, take the small capillary hemorrhoid described; one application to it of fuming nitric acid, properly made, cures it forever. We will now consider the treatment of hemorrhoidal tumors by the ligature; and when I speak of the ligature operation I mean the operation by incision and ligature known as Mr. William Allingham's. He thus briefly describes it in his works:

"After the patient is etherized and placed in position, gentle but complete dilatation of the sphincters is done." (I desire here to impress upon all who do not know it from experience, the *very great importance* of gentle but entirely complete dilatation, and consequent temporary paralysis of the sphincters before any operative interference.) "The hemorrhoidal tumors are brought down one by one; then, with a pair of

sharp scissors, the pile is separated from connection with the muscular and submucous tissues. The cut is made in the sulcus, or white mark which divides skin from mucous membrane. This incision is carried a distance up the bowel until only an isthmus of vessels and mucous membrane is left; a strong silk ligature is placed at the bottom of the groove, and, the assistant drawing the pile well out, the ligature is tied high up at the neck of the tumor as tightly as possible. A portion of the tumor may now be cut off, or the whole returned within the bowel. After all tumors are thus treated, a suppository of morphia is placed in the rectum, a pad of antiseptic wool is placed over the anus, and a tight T bandage completes the dressing." This briefly is the ligature operation, and it probably has effected more cures of hemorrhoidal disease than all the other surgical procedures combined.

That this operation is grounded upon a sound surgical basis no practical surgeon can dispute. Mr. Allingham (than whom there is perhaps no greater authority living) has performed this operation in private and hospital practice more than two thousand times with but three deaths, and he says of it: "I do not think in the whole range of surgery there is any procedure worthy of the name operation which can show a greater amount of success or smaller death-rate than the ligature of internal hemorrhoids." And again he says: "It is both the safest and quickest operation to perform in all cases of well-formed hemorrhoidal tumors."

Dr. Bodenhamer, of N. Y., says: "I have yet to encounter my first serious accident."

Dr. Gross says: "The operation is as simple of execution as it is free from danger and certain in its results."

Recognizing that a paper of this kind should contain something more than a mere compilation from books accessible to all of us, and being able to give very little from personal experience, I took the trouble to obtain by correspondence the following opinions upon the subject from eminent men, which certainly embody more recent views as to treatment than any of the textbooks.

I submitted, to the men whose names follow, the following five questions on mooted points in the surgical treatment of hemorrhoidal tumors. I will read you the first question and their separate replies.

The first question was: "To what extent do you carry out in your surgical treatment of hemorrhoids the principles of antisepsis as ordinarily employed in operation wounds?"

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1. "Only in having my instruments and the water used aseptic."—D. Hayes Agnew, Philadelphia.

2. "General cleanliness."—Thomas G. Morton, Philadelphia.

3. "Thorough cleansing before, and frequent irrigation after operation, with bichloride solution."—Louis McLane Tiffany, Professor of Surgery, University of Maryland, Baltimore.

4. "I treat antiseptically as far as the nature of locality permits—using corrosive sublimate cloths, iodoform, etc."—John H. Brinton, Professor of Clinical Surgery, Jefferson Medical College.

5. "To its fullest extent."—Joseph D. Bryant, Professor of Clinical Surgery, Bellevue Hospital Medical College.

6. "I use all necessary antiseptic precautions."—Dr. William Bodenhamer.

7 and 8. Mr. Allingham, of London, and Dr. Kelsey, of N. Y., in reply to my queries kindly mailed me their latest books from which their views are to be taken. Neither refers to the antiseptic principle at all in his book.

9. "To obtain as much cleanliness as is possible in this part of the body—bichloride solution externally and Thiersch's solution within the rectum and anus."—John A. Wyeth, N. Y.

The second query was: "Do you rely entirely, or at all, on cocaine or any form of local anaesthesia in your surgical procedures for the cure of hemorrhoids?"

1. Dr. D. Hayes Agnew, of Philadelphia, says: "No."

2. Dr. Thomas G. Morton, Surgeon to Pennsylvania Hospital, says: "No. Often do not use anaesthetic for internal, but always for external hemorrhoids."

3. Dr. Louis McLane Tiffany says: "Compression by clamp."

4. Dr. John H. Brinton says: "I have employed local, but prefer general anaesthesia from ether inhalation."

5. Dr. Wm. Bodenhamer, of New York, says: "I now use cocaine as a local anaesthetic in all cases in which general anaesthesia is not particularly indicated. I have found it of much value."

6. Mr. William Allingham, of London, says "No. It is only of use when mucous surfaces are to be operated upon—as cocaine does not sufficiently deaden the sensibility of the skin to make it of practical service."

7. Dr. John A. Wyeth says: "I have used cocaine (4 per cent. solution), but lately have found that most patients do not suffer

more from the carbolic mixture than from the distention by cocaine. When I do the ligation operation, ether narcosis."

8. Dr. Charles B. Kelsey says: "In minor operation the drug used hypodermically is perfectly satisfactory. In larger ones it is not to be relied on absolutely, and may have to be supplemented with ether."

9. Prof. Joseph D. Bryant says: "I have done so, but do not make it a practice—can be done easily if case be a simple one."

The third question asked was: "Are you convinced from experience of the permanency of the cure of hemorrhoids by the injection method of treatment?"

1. Dr. D. Hayes Agnew: "Yes, in well-selected cases."

2. Dr. Thomas G. Morton: "By no means."

3. Dr. L. McLane Tiffany: "My experience does not justify an opinion."

4. Dr. John H. Brinton: "I have seen cases operated on by others where the hemorrhoids still existed, but I knew nothing of the extent of operation. I have seen the saddest results in the way of sloughing from the injection of carbolic acid. If used at all, believe it should only be when pile is thoroughly clamped before injection. I would only resort to this method in exceptional cases."

5. Dr. Joseph D. Bryant: "Am convinced that in selected cases this method causes as good results as any; but it cannot produce better final results than tying."

6. Dr. W. Bodenhamer: I have given Dr. Bodenhamer's views under the description of this operation, in which he condemns it in severe and measured terms.

7. Dr. C. B. Kelsey says: "It is neither radical nor certain in its results."

8. Mr. William Allingham: "The injection of carbolic acid into the interior of piles may in some instances stop the bleeding for a time, yet it cannot and does not in any way remove the tumors."

9. Dr. John A. Wyeth: "I believe injection will cure a hemorrhoid thoroughly injected. The process of cure demands inflammation (preferably sub-acute) and cicatrization (or shrinking)."

The fourth question was: "Did you ever know personally of a permanent cure of internal hemorrhoids by simple dilatation of the sphincters alone?"

This query was asked because in this city during the early spring and summer this method was practiced by a notorious quack on many people, who, after submitting to it, believed themselves cured; but in several of

them, to my personal knowledge, recurrence has taken place—not, however, until the disappearance of their former medical attendant and their cash. This method has some legitimate foundation, however, having been advocated by Verneuil and other eminent French surgeons.

1. Dr. D. Hayes Agnew says in reply to it: "No."

2. Dr. Thomas G. Morton: "No."

3. Dr. L. McL. Tiffany: "No experience."

4. Dr. John H. Brinton: "I cannot answer positively."

5. Dr. Joseph D. Bryant: "Have known relief to follow, but not a permanent cure."

6. Dr. Bodenhamer: "I never did."

7. Dr. John A. Wyeth: "No; and despite Verneuil's statement, cannot believe it possible."

8. Mr. Allingham: "It will give wonderful relief in selected cases."

The fifth and last question was: "What surgical procedure do you consider the safest, most generally applicable, and yielding the best permanent results in the surgical treatment of hemorrhoids?"

1. Dr. D. H. Agnew: "When large, I prefer the ligature."

2. Dr. Thomas G. Morton: "My universal practice is the ligature for internal and the ligature and excision for the external variety."

3. Dr. L. McL. Tiffany: "I probably use clamp and cautery as often as any other."

4. Dr. John H. Brinton: "I prefer ligation of internal hemorrhoids. I use a fine linen cord soaked in sublimate solution, and when the hemorrhoid has a partial cutaneous covering I form a track with knife in the skin covering, to divide nerves, and thus avoid pain after the old method."

"My opinion is decided in my preference for this method."

5. Dr. Joseph D. Bryant: "Ligation with cat-gut."

6. Dr. Bodenhamer: "I consider ligation, if judiciously and properly applied, the simplest, safest, most certain, and most effectual of all known methods. It has the recommendation, the advocacy, and the indorsement (with but few exceptions) of all the leading surgeons of Europe and America."

7. Dr. John A. Wyeth: "Allingham's operation—ether narcosis."

8. Dr. Charles B. Kelsey: "I prefer the clamp and cautery to all other radical measures, as being less painful and giving a quicker recovery."

9. Mr. Allingham: "Ligature with incision, for reasons given under the description of the operation."

From a careful review of the best recent works on the subject, from a very limited personal experience, and from the very able opinions obtained by correspondence and just read to you, I have drawn the following conclusions:

1. The principles of antisepsis should be carried out (as far as possible) in this as in all other surgical operations.

2. Local anaesthesia is not to be relied upon in surgical procedures for the radical cure of hemorrhoids.

3. The injection method of treating hemorrhoidal tumors is not reliable, not safe, and not comparable with safer and surer methods.

4. Simple dilatation of the sphincters alone probably never cured a case of well-developed hemorrhoidal tumors.

5. Mr. Allingham's operation by the ligature with incision is beyond a doubt the safest, most generally applicable, and yielding the best permanent results in the surgical treatment of internal hemorrhoidal disease.

PREVENTION OF CONCEPTION.

BY THOMAS A. POPE, M.D.,
CAMERON, TEXAS.

I accept the wise and timely suggestion in the *REPORTER*, Sept. 15, 1888, to discuss the prevention of conception, because the subject is one that comes almost daily before every physician; and, as there has not heretofore been any extended public discussion of it, every physician has heretofore had to deal with the matter as seemed best to himself, without advice or help from his professional brethren. In other matters we are greatly aided by the recorded experiences and conclusions of others, but on this subject we get no such help.

For myself, I have some decided opinions about the prevention of conception, and if I am wrong I would be grateful to be set right. One man, however wise, might easily come to wrong conclusions if left to himself, but a large body of educated, fearless and conscientious gentlemen by the thorough discussion of any question are certain in the end to be right.

I believe this world would be better and our people happier if the child-bearing period of woman began at twenty-two and ended at thirty. If such were the case, there

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would be less poverty, ignorance, crime and disease, and of course more intelligence, refinement, comfort and happiness. The vital statistics of the United States have never been gathered and collated as they should have been in the past, and ought to be in the future, so there is no way of arriving at exact conclusions concerning the increase of population. But the census of 1880 showed nearly three-fourths of a million net gain from births. This would show a net increase of about one and one-fourth per cent. per annum. But even if the net increase of our population from births and immigration should amount to two per cent. per annum it would be many years before the conditions that Malthus feared in Europe would obtain here. Malthus perhaps forgot when he wrote that almost one-half of the world was unpopulated, and that ages must elapse before the whole would be settled as densely as some parts of Europe were sixty years ago. But while we need not perhaps urge the same reasons now that Malthus did for limiting the population, the time will soon come when the question: Wherewith shall all these people be clothed and fed? will be a vital one. There are no new worlds to conquer. Every inhabitable part of the globe now has its tenants, and in many portions of it the population is now so dense that mere existence is a struggle, and the population is everywhere increasing. The laws just passed by Congress restricting Chinese immigration and prescribing the return of improper immigrants from Europe constitute the beginning of a struggle for the survival of the fittest that henceforth will not cease as long as mankind shall continue to multiply and replenish the earth.

Let us now examine somewhat in detail some of the reasons against too frequent conception. And, first, it often causes the death of the preceding child. It is a very common occurrence for the wife to become pregnant within from two to six months after confinement, and then of course the little babe is weaned and must be artificially fed. I cannot state accurately how many of children so weaned and artificially fed die; but I am certain that at least one-half of them die in infancy, and half of those that survive are neither strong nor healthy.

It will, of course, be understood that I am speaking of poor people, where the wife is compelled to work and cannot procure for the child the things it needs or give it the attention and care it should have. And I here remark that very frequent conception is now mostly confined to the poorer class.

The rich, in town and country, already limit the number of their offspring; but for a different reason, perhaps, from that for which I would limit it among the poorer people. I have no doubt that most of the criminal abortions occasionally seen in the country and so often occurring in the cities are due, not to the fact that no children are wanted, but to the fact that the mother feels she cannot educate and care for so many, and becomes desperate and commits a crime rather than bear children she knows cannot be adequately provided for.

There are very many women who ought not to bear children because their children are likely to be diseased in body or mind, and, if they survive childhood, will be a burden to themselves and society. This is a most important reason, and the subject deserves a chapter to itself; so I shall only advert to it here, and leave its further consideration to some future time or other writer.

In the year 1880 there were 5646 deaths from child-birth in the United States. The number of women who died that year in child-birth was about equal to the number who died from pneumonia within the child-bearing period. If it were possible to permit only those to become pregnant in whom no contra-indication exists, the death-rate in child-birth, instead of being nearly four in each thousand, would be *nil*. Most women who bear many children become prematurely old. This is rather because of the mental anxiety and worry of watching over and caring for so many children than from the effect of child-birth, but this with its attendant troubles is no doubt an important factor. As a rule, women at forty, who have given birth to not more than three or four children, are, other things being equal, in better health and every way better preserved than the women who have given birth to from six to ten. I cannot think that the Creator intended that woman—the best and fairest part of His handiwork—should become a mere machine for the propagation of the species; but such she would become if she were perfectly healthy herself, and had a healthy husband, if no means were used to limit the number of her offspring. Such a woman would be confined almost exclusively to her home, social intercourse with friends would be limited, and, however bright an ornament of society she might have been, it would know of her only through the birth and perhaps death column of the daily paper. Some of her children would be neglected, and she could

give to none of them the attention she could have given if the cares of maternity had not been so many and so exacting. The health of children depends greatly on a mother's care, and if she has two or three, or even four children, she could look carefully after each child and protect them all from disease. From the reasons given, it seems certain that prevention of conception, if judiciously practised, would lessen the death-rate of both mothers and children and almost eradicate many hereditary diseases; our offspring would be healthier and happier; idiocy would be unknown, and insanity infrequent.

Now let us look for a moment at the economic side of this question. To clothe, feed and educate his offspring properly would require an addition to the parent's income of at least \$400 at the birth of each child. That is, if man and wife could live comfortably on, say, \$800 a year, then one child would call for \$1200 for the three—a second child \$1600 for the four, and so on. What proportion of our population would be able to meet the increased expenditure so essential to making of the child a good and useful member of society?

There are to-day in the United States about 9 millions of families, averaging about seven persons to each family. Now I think it fair to assume that the net average income of over one-half these families would fall below \$800 per year, and perhaps even less than \$600. One-half of the families of the United States cannot properly feed and educate their children, and with a majority of them it is a struggle to maintain an humble home with few comforts and no luxuries, and the little ones must at the earliest possible moment become breadwinners in order to eke out their parents' scanty income. Does it not seem like the greatest cruelty for a man and woman, with no visible means of support, who live by the proceeds of their daily toil, which is perhaps barely sufficient for their own needs, to bring into the world a large family when they must know that every child has no heritage but one of poverty, ignorance and toil? When they know that these children in the period of childhood and youth, when in need of judicious care and training, must begin a life of labor and mental darkness with but little promise of any lightening of the load which their very existence has forced upon them? The men who lead in every sphere of life, in politics, in war, in science, or in religion, do not, as a rule, lead because they have bigger or better brains than many of their fellow-men, but rather because they

had more judicious training and better opportunities to improve and cultivate the talents given them by nature. I am sure that thousands of men and women sleep in unknown graves to-day, who, if they had had early and kindly care and been given the proper opportunities, would have been famous in some line, and would have had marble monuments instead of pine boards to mark their final resting-place. If the number of children were limited, better opportunities and better care would be for all, and all could have a start in life so fair that success would come to all who deserved it.

Again, crime would be lessened by limiting the number of offspring, because there would be less offspring of vicious parentage and, as each child could be better educated and have more comforts, there would be less temptation to begin, as most criminals do, a life of crime in youth or childhood. I have recently read an article in the *Amer. Journal of Obstetrics* which dwelt considerably on the "crime for which Onan was so severely punished." If the distinguished author had read his Bible before he wrote the article, he would not have said "The boastful citizen (of to-day) . . . does not hesitate to commit the crime for which Onan was so severely punished," because he would have seen that Onan was punished for attempting to evade the consequences of a custom which would itself be regarded as indecent to-day. If the author of the article above quoted means that "wasting seed" is a crime, then a man would commit a crime every time he had intercourse with his wife after she became pregnant, for his seed would then certainly be wasted. And it would be a crime to have intercourse with her at any period when she could not become pregnant. To prevent being branded as a criminal, a man would have to possess a most thorough and scientific knowledge of the physiology of generation, and govern himself accordingly. I say there is no law, human or divine, written or unwritten, that forbids the prevention of conception when any valid reason for the prevention exists. And, in this, I am not saying anything in favor of licentiousness or providing a way to cloak immorality. I am speaking of persons lawfully bound together in wedlock.

Paul, in his letter to Timothy, says that a man who does not provide for his family is worse than an infidel. Then, would it not be a crime against society and a sin against religion to beget children when one knew beforehand that he could not provide for them?

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The Editorial in the *REPORTER* of Sept. 15 suggests several other points that deserve attention, and I hope others will supply what I have omitted, which yet ought to be said. For the present I will content myself by calling attention to the following remarks of Dr. J. Ford Thompson, at a meeting of the Gynaecological Society of Washington, D. C., on May 28, 1888.¹ "A great deal has been said and written on this subject that is not true either scientifically or in fact. There is no proof that preventive measures do any harm. Over-indulgence may affect the male injuriously, but self-limitation does not. What difference physiologically does it make whether the emission takes place in a condom or in the vagina? None, because the sensations are the same and the effect on the male is the same. The most common method is withdrawal, and what difference does it make? There is more room for unpleasant effects than from emission in a sheath, but he doubted any deleterious effect. The sexual act is not completed, but the emission takes place, consequently he doubted whether this method was attended with any injurious effect upon the male.

"Now, on the part of the female, let us consider the effects of these methods upon her organism. With the use of the condom the sexual act is completed. He did not believe in the many theories of the part the female organ takes in coition, such as the descent and opening of the cervix and the aspirating effect of the uterus. The method of withdrawal may occasionally injure a female, but such cases are not as frequent or numerous as we are led to suppose. The orgasm in the female is not hastened by the emission of the male, but precedes it. If this is true, then withdrawal is not injurious to her; and if it is not true, the only effect is to leave her unsatisfied. The use of the hood by the woman is practically the same as the use of the condom by the man, and does not interfere with the complete act of coition. So far then as mechanical appliances are concerned, there is no proof that they do any harm to either party and their evil effects have been greatly exaggerated. Withdrawal is the only case where physical injury may result, and even this is very doubtful.

"The cold-water douche may have a deleterious effect upon the female, but it is questionable whether tepid water or water impregnated with carbolic acid or astringents injures her. It cannot be proved that any of these methods is injurious."

¹*American Journal of Obstetrics*, Sept., 1888.

A SEVERE RAILROAD ACCIDENT.

BY T. F. McGEE, M.D.,
TRINIDAD, COLORADO.

J. T. Link, thirty-two years old, brakeman on the D. T. & F. W. R. R., met with injuries external and internal; the latter of which were very severe and accompanied with great shock. On September 9, while sitting on the side of freight train, running at usual speed, he was looking back at a hot box, when he was struck on the left side of the head, while passing through a narrow bridge, splitting his ear, and throwing his body through the bridge to the ground, some distance below. He was brought to this city, some five hours later, and by instruction of Supt. Grover of said road, he was placed in my care for treatment. I was ordered by telegram from Chief Surgeons Drs. Beall and Adams, of Fort Worth, Texas, to forward the injured man to the hospital, if his condition would admit; but, owing to his severe shock and the nature of his injuries, I declined to do so.

He was struck on the left side of his head, and his right shoulder, and almost the entire right lobe of his liver, together with a considerable portion of the dorsal spine, were so severely injured as to cause ecchymosis, which appeared several days afterward, showing the deep nature of the internal injuries. There was also slight haematemesis, and slight hemorrhage from the cranium—not from the split ear. When I first saw the patient, his pulse was small and feeble, but regular; inspirations about fourteen, every breath causing an agonizing pain. I gave him a hypodermic injection of sulphate of morphia, and ordered hot applications to the injuries, and left small doses of morphia to be given by the mouth, as might be necessary to keep him quiet during the night, leaving word to let me know in case he became restless.

I visited the patient next morning, found his pulse seventy-two and very full, and that his bladder had acted once during the night. In the afternoon his pulse ran up to ninety-six; his temperature was 102° F., and he was suffering greatly. I ordered Rochelle salts to move his bowels, and hot flax-seed poultices sprinkled with chloroform liniment to be put on over the entire injured surface, as hot as the patient could bear. Under the above treatment, he became more quiet, his bowels moved freely, his pulse came down to normal, and his temperature fell to 99° F. But these favor-

able symptoms lasted only a short time, when he began to suffer as much as ever; the hot poultices were continued; and as long as they remained hot and he was kept under the influence of very large and often repeated doses of morphia, his sufferings were to some extent bearable.

The fourth day he began to have hemorrhage from the bowels, averaging from eight to sixteen operations per day. From the fifth to the sixth day from the time he began to pass blood from the bowels, the discharges assumed the character usual in intestinal catarrh. Dr. Omstead of this city saw the patient with me the third day after the accident; and, on account of the high-colored urine and the full pulse, suggested five-grain doses of antifebrin every four hours.

The suggestion was a good one. Under the influence of antifebrin the kidneys acted much better, and the patient rested much easier.

His temperature never exceeded 102° F.; and his pulse never ran over a hundred. His urine was high-colored, and his suffering was intense. At times he had stertorous breathing, which of course alarmed me, with frequent and severe hiccoughing, which did not lessen my fear; and the above symptoms lasted from eight to ten days.

The patient is now able to walk about with his arm in a sling, as he still suffers more or less pain under the right shoulder-blade. He informs me, since his recovery, that he has no recollection of anything during the first five days succeeding his injuries.

SIMPLE ELECTRICAL APPARATUS.

BY SUMNER GLEASON, M.D.,
CARTHAGE, NEW MEXICO.

Electricity is admitted to be a potent factor for good when properly used in some of the derangements of the human system. Here there is a large field open for research and a rich harvest to be gathered. The medical profession is just beginning to learn how to make use of this agent; but a large number of physicians are still in ignorance as to the methods of operation or the results to be obtained. This is in great part due to the expense of the apparatus necessary. Now a convenient galvanic battery for office work can be made for a very few dollars, and any physician of a mechanical turn of mind will take pleasure in putting it together. Zinks and carbons with attachments can be obtained from any manufacturer of electrical apparatus. These should

be attached to a thin board, so that they can be raised from the cells when necessary to add more water. Cells can be made of old bottles. To cut off the tops, place the bottle in the corner of a box which holds a steel wheel glass-cutter at the place at which it is desired to cut the bottle; turn the bottle until the lines meet; then heat the line in a flame for a moment and plunge the bottle in cold water; the top will then split off neatly in the line marked. Paraffine the inside of the jar for about an inch from the top. The carbons and zinks should also be paraffined above the level of the fluid, in which they may remain constantly. The fluid consists of a saturated solution of bichromate of potash and muriate of ammonia, the latter being pure. Thirty-six cells will give enough current to commence with, and, after becoming familiar with its effects, as



- A. Wooden box.
- B. Glass tube filled with water.
- C C. Binding-posts.
- D. Straight copper wire.
- E. Coil of copper wire.
- F F F. Corks.
- G G'. Screws.

many cells can be added as are desired. A milliampercere-meter is not a necessity for the novice. He will learn more by experimenting on his own person; but, of course, cannot expect to obtain as good results from his battery.

Above is a drawing of a rheostat which can be made for a few cents. This is indispensable where there is no arrangement for increasing the current one or two cells at a time. It serves the purpose of increasing and decreasing the current without shock to the patient; it can be attached anywhere in the circuit, and should always be used where a steady current is passed through a sensitive part. All that is necessary to buy is two binding-posts and screws, costing ten cents each. A glass tube can be made of an

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ordinary glass syringe, cutting off the end with a file. In one end fit a cork to which should be attached a binding-post, the screw passing through the centre of the cork. To the head of the screw attach a copper wire coiled so as just to fit in the tube. This should be so that it can be removed easily and the tube filled with water, which should be done before each sitting, as the water decomposes rapidly. In the other end of tube, place one or two corks. In one end of a small wooden box cut a hole just large enough to allow the tube to slide easily. At the other end attach a binding-post, and to the screw-head on the inside a straight copper wire to pass through the centres of the corks FF. Now a current of electricity passing through this wire meets the resistance of the column of water, and as the tube is pushed in this resistance grows less, until the wire is in contact with the screw G; the current is then at its maximum intensity. The tube should of course be pulled out before the current is broken.

•••

risk of injuring anything beneath the membrane; the peritoneum is then cut into. The moment the incision is made, one or two fingers, or rather the index finger and the thumb, are introduced. In the case just referred to, the diagnosis was not positive, only probable, before opening the abdomen; but as soon as Mr. Tait had introduced his fingers into the abdominal cavity, he said that it was a case of extra-uterine pregnancy with rupture of the tube. Probably five minutes were required to bring up the ruptured cyst and ligate the tube with the Staffordshire knot. After removing the tube and ovary, water was poured in through a funnel to which was attached a rubber tube with a nozzle. The metal nozzle was pushed around in all parts of the abdomen, so as to wash out all of the clots. In this particular case, two pitcherfuls of water were used. A drainage-tube was introduced, and three stitches used to close the abdominal incision. This patient did not have a temperature above 100° , and when seen three days later her recovery seemed almost absolutely certain.

DR. PARVIN exhibited the following instruments:

The Axis-Traction Forceps

of Dr. Stephenson, Professor of Obstetrics in the University of Aberdeen. The forceps closely resembled the Simpson forceps, being only a little longer and the pelvic curve greater. The traction is hooked on in front of the lock after the forceps is applied.

DR. WM. GOODELL thought that after seeing Stephenson's forceps, he could justly lay claim to all priority in the axis-traction device. Many years ago, in his work at the Preston Retreat, he found that his back so often gave out while making axis-traction with his left hand on the lock of the ordinary forceps, that he sewed a stirrup to the end of a leather strap. The other end of the strap he wound around the forceps handles near the lock, and in the stirrup he placed his foot. He usually hung the strap so near the floor that his heel rested on the latter, the traction force being made merely with the toes or ball of the foot. He thought Dr. Price had probably seen this impromptu device hanging on a gas-fixture in the lying-in room of the Retreat. Of course the woman lay on her back with her nates drawn over the edge of the bed.

DR. PRICE remarked that he had seen the device spoken of by Dr. Goodell.

SOCIETY REPORTS.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, October 4, 1888.

DR. T. M. DRYSDALE in the Chair.

DR. THEOPHILUS PARVIN exhibited a specimen of

Extra-Uterine Pregnancy,

removed by Mr. Tait in the latter part of August. Pregnancy was supposed to have advanced six or seven weeks. Rupture had taken place two days before the operation. The patient was doing well when Dr. Parvin last heard of her condition, four days after the operation. He thought that Mr. Tait was really the most wonderfully expert surgeon in abdominal diseases he had ever seen. In his work no antiseptics are used; perfect cleansing of the hands is accomplished with soap, water, brush and towel; the abdomen is perfectly cleansed; the incision is through the skin and underlying tissues; haemostatic forceps are used if necessary, but frequently are not required. Forceps are used to take up the tissues as the peritoneum is approached; the peritoneum is raised almost an inch, so that there is no

DR. B. F. BAER read the following report of two cases of

Multilocular Ovarian Cystoma

of unusual size and very rapid growth.

Mrs. X. was sent me by Dr. J. A. Clark, of Bedford, Pa., and on July 31 entered my private hospital. She is 28 years old; married; has had two children after normal labors, the youngest being six years of age. About nine months previous to this date she was attacked with severe pain in the right ovarian region and was confined to bed for several weeks. Her menses had always been regular, but at this time the flow was profuse and continued two weeks. Soon after this attack of pain and metrorrhagia she noticed a swelling in the painful region, on the right side. She rapidly increased in size and began to lose flesh, and occasionally to have attacks of pain and metrorrhagia similar to the one just noted, the flow on several occasions lasting for a month. Her abdomen was enormously distended, especially in the upper portion. It was rather symmetrical, dull on percussion all over the anterior and lateral portion, except in the lumbar regions, where slight resonance was observed. There was fluctuation in the lower part, but in the upper portion it was very obscure. The skin on the lower surface of the abdomen was in a condition of elephantiasis.

Vaginal examination revealed the uterus slightly retroverted, rather mobile, and gave a sound-measurement of three inches. The lower surface of the tumor could just be felt by the vaginal examination. The patient had a very weak pulse, indeed it could not be felt at all at the left wrist, and she had great dyspnoea on the slightest exertion.

Operation was performed on August 2. I was assisted by Drs. J. C. Bowen, G. H. Franklin, J. A. Clark and H. C. Bloom. An incision three inches in length was made in the usual position. The skin at the point of the incision was fully half an inch thick and very vascular, and considerable subcutaneous adipose tissue was present. As soon as the tumor was reached it presented the appearance common to "ovarian growths," but it was found to be closely adherent to the abdominal wall. After separating as far as the finger would reach, the tumor was punctured with Tait's large trocar, and about four gallons of greenish fluid drained away; but only the lower portion of the tumor collapsed, the greater and upper portion remained as before. This was punctured in a number of places without removing the

instrument from the cavity which had been drained, but nothing followed. The opening in the tumor was now enlarged and the hand introduced; the multilocular condition was broken down, large pieces of semi-solid substance being torn loose from the cavity of the tumor and brought away, together with a great deal of semi-fluid débris. As soon as room was gained, the hand was carried outside the tumor, when it was found to be adherent to the liver, stomach and everything with which it came in contact. These adhesions were carefully separated and after considerable effort the remainder of the tumor was finally brought out through the incision, which had been previously increased to $3\frac{1}{2}$ inches. The pedicle, which was found to be thick and quite vascular, was transfixated and ligated, and the tumor cut away. The cavity was irrigated with filtered, boiled water, as much as two gallons being used. The irrigating tube was carried in every direction until the water returned clear. The right ovary was not removed, it being in apparent health. The wound was closed around a drainage-tube. There was considerable shock. The pulse could not be felt at either wrist, and it was two days before it returned, although the patient seemed to be doing well. The usual after-treatment was carried out, and the patient has made an excellent recovery. She went home (two hundred and fifty miles) on the 27th day, and still remains in good health. The temperature never rose above 100° ; the drainage-tube was removed on the second day. The tumor was a multilocular cyst and weighed about 90 pounds.

On September 5 I was asked by my friend Dr. R. Armstrong, of Lock Haven, to meet him in consultation over a patient with abdominal tumor, who, he stated, was in such extreme condition that he feared she might not live until my arrival. I saw the patient on September 6. She is 21 years old, and single; puberty had occurred at twelve, and menstruation had always been profuse, coming on every three weeks and always being attended with some pain; she did not consider this abnormal, and so far as she knew was perfectly well up to four months before the above date. In the latter part of April of this year, after unusual exertion about the house, she was suddenly attacked with severe cramp-like pain in the right iliac region, so severe indeed the neighbors were alarmed by her outcries. This attack occurred about the time of her expected menstruation, and continued until the flow followed, when she

gained considerable relief. But she remained ill from that time; she was able to go about, however, in the intervals between the series of attacks of pain of similar character which now followed. Within two weeks after the first attack she noticed that her abdomen was increasing in size in the painful region, and from that time to the time of my visit, just four months, her abdomen had grown to an enormous size. I found her occupying a semi-recumbent posture, and breathing with difficulty. She was emaciated to such a degree, and the tumor was of such size, that she was almost hidden from view beneath it. The surface of the abdomen was purple from interference with the capillary circulation, and the veins were greatly distended. The abdomen was symmetrical and smooth. Fluctuation was rather obscure. There was dulness on percussion all over the anterior and lateral surfaces of the tumor, except at a point far back in the left lumbar region, where slight resonance was found. On the upper right border of the tumor, in the region of the liver, there was an apparently solid mass, shaped somewhat like the liver, suggesting the possibility that the cyst had grown from that organ. This was given more prominence on account of the rapidity of the growth. The patient was unable to retain anything on her stomach, and she had not slept, except at short intervals, for weeks. Her bowels were constipated and the urine was passed frequently and in small quantities. Her pulse was 140 and very feeble. Her expression was an appealing one, and she begged to be relieved.

A tablespoonful of whiskey was given and repeated in two hours, just before the administration of the anæsthetic. I was ably assisted in the operation by Drs. Armstrong, Ball and Watson, of Lock Haven. An incision two inches in length was made. The surface of the cyst was adherent to the peritoneum. After separating the adhesions as far as I could I plunged a large trocar into the tumor. But the contents were semi-solid. I therefore cut through the cyst wall and proceeded to break up and remove the contents. The cyst was adherent to everything it touched—liver, stomach, and other viscera; but the adhesions were weak and in ten minutes' time the tumor was removed, and the pedicle, which was thick and vascular, was ligated. The omentum was so firmly adherent to the cyst that it was ligated and amputated. The friable cyst wall was ruptured in many places and a great deal of the viscid semi-fluid material escaped into the abdominal cavity, but I

did not lose time in trying to prevent this. When the tumor was removed what was left of the patient was an exceedingly small portion. The emaciated abdominal walls lay close to the spinal column and sunk into the pelvis. She looked more literally "nothing but skin and bones" than anything I had ever seen before. The abdominal cavity was thoroughly washed out by irrigation through a fountain syringe, and I was careful to pass the nozzle high up among the intestines and under the surface of the liver and diaphragm. The water returned clear and the incision was closed around a drainage-tube, and the patient returned to bed with a better condition of pulse and appearance than she had had before the operation. She did not show any evidence of shock and was conscious almost as soon as she was placed in bed. Her body was so emaciated that it was necessary to pack with cotton about the pelvis and along the spinal column, as the bones almost projected through the skin, and at several places bed-sores were apparent. The right ovary seemed smaller even than its natural size and appeared healthy; it was therefore not removed. The after history of the case has been without event. Her temperature never rose above 100° ; it was normal on the third day after the operation. The pulse gradually diminished from 140, and was normal on the fifth day. The drainage-tube was removed within thirty-six hours after the operation. The sutures were removed on the eighth day, when union was found complete, except at the lower portion where the drainage-tube had been, and this has since healed. She began taking solid food on the third day, and on the fourth day her bowels were moved. The tumor weighed about 75 pounds.

The points of considerable interest in these cases are the location, character, and severity of the early symptoms, as well as the location of the tumor when first noticed (on the right side), while the tumors were of the left ovary, the right being perfectly healthy; the large size and very rapid growth of the tumors; the rapid recovery of the patients although in extreme condition, especially in the case last mentioned; the fact that the two cases are alike in nearly all particulars, the only difference being that in the second case the rapidity of the development was much greater, and the severity of the symptoms likewise greater; and lastly the method of removal of the tumor, that is, the breaking up of the semi-solid contents with the hand, thereby permitting their removal through a very short incision. I wish here

especially to call attention to a fatal case which occurred in my practice several months ago, and which forcibly illustrates that there may be danger in introducing the hand for the purpose of breaking down contents of the tumor, not knowing exactly the location of the intestines. In the case referred to, the friable wall of the main cyst had ruptured and some coils of intestine were found to be in the cavity and closely adherent to the more solid portion of the contents. Very careful manipulation was necessary to separate the bowel, which was finally done after considerable time had been spent in the effort. Ordinarily, however, where the cyst has not previously ruptured, the procedure is a safe one when due care is observed.

DR. M. PRICE reported a case of

Pyosalpinx with Rupture.

On the sixth of September I was called to Mrs. —, who had symptoms of miscarriage, with pains, hemorrhage and slight odor to the discharge. She refused to permit an examination, saying she knew she was not pregnant. I left her with the injunction that when she was ready for me to examine her to send for me. On September 10, I was again called, and found her in great pain; the discharge of blood and broken down placenta was of the most offensive character. She stated that she had been perfectly regular up to her last period, which was delayed about one week. She had considerable fever, a temperature of 102° , and had had that morning a severe chill. On examination the uterus was found about four inches in depth, with part of a rotten placenta adherent to its right posterior wall. The uterus was in good position and perfectly movable, with both tubes enlarged and thickened, and at this time could not have been adherent to any surrounding structures. I removed the placenta with considerable difficulty, used intra-uterine irrigation with hot water containing boric acid, which for a time gave her great relief. These irrigations were continued and the uterus washed out twice a day for three days; all this time the tubes continued to enlarge, until they must have contained several ounces of matter, but could have, at this time, been easily removed. The irrigations into the uterus were discontinued and those of the vagina were kept up. I became very much alarmed at her condition and stated to the husband that an operation was needed to save his wife's life. This he refused, and begged that I should do all I

could without the operation. I yielded to his request much to my regret, for I felt that nothing but an immediate operation and removal of the tubes would save her life. I believe that any man, treating a case of this kind with the symptoms as positive and the indications for operation as plain as they were in this case, should retire from the case if an operation is refused, for by so doing he clearly indicates that his mind is made up as to the treatment, and by withdrawing shows to the medical attendant who may be called to the case the proper line of treatment; if the latter does not take the warning, the post-mortem will follow and show who was right. There were several well-marked changes in her condition indicating rupture or leakage from the tubal abscess, and her condition steadily grew worse until the 20th, when in consultation with my brother, we persuaded the family and the patient to let me operate and give her that chance for life, as she was in a very bad septic condition. As the consultation was at a very late hour at night, she was opened early the next morning, Sept. 21. I found the internal organs matted together, uterus much enlarged, both tubes enlarged and ruptured, adherent to everything they touched, pelvis full of pus cavities, pus cavities almost up to the kidneys on both sides; everything was in a semi-gangrenous condition. There was little bleeding from ruptured adhesions or from the wound made in opening the abdomen, which is never a good indication. A great quantity of pus was evacuated, at least two pints; it was of the most offensive character. Irrigation and drainage were used. The patient was a very large woman, consequently the longest drainage-tube we could find was used. She rallied from the ether and for the first six hours there were discharged from the drainage-tube two pints of very offensive serum. It gradually lessened in quantity but increased in offensive character. A cleaning of the tube was made every half-hour; after cleaning, warm boracic water was injected through the tube. It improved matters only for the moment. The patient died twelve hours after the operation. Present at the operation: Drs. Joseph Price; E. W. Cushing, of Boston; Atherton, Toronto; Roseburg, Hamilton, Ontario.

DR. W. H. PARISH said that his remarks on this subject of pelvic abscess made at the recent meeting of the American Gynaecological Society had been misquoted. He had stated there, and wished to repeat here,

that these abscesses should be opened very early. If operation were not resorted to, the patient would most probably either die or become a confirmed invalid. He was not one of those who believe that pus always originates in one particular point in the pelvis. He did, however, believe that the large majority of cases occur because of pus primarily in the tube. He believed also that an uncertain number occur from pus originally formed in the areolar tissue, beginning probably because of lymphangitis of that particular locality. The question arises, how best to operate in these cases. He held that there could be no absolute rule of procedure. He believed that in the majority of cases it is wiser to make an opening in the median line and explore the peritoneal cavity, unless we are very certain that the abscess is not in the tube or ovary. If we are sure that there is no involvement of the appendages and that the pus is not intra-peritoneal, the abscess may be opened without going into the cavity. He called attention to a procedure he had adopted in a few instances, where small abscesses were located in pelvic areolar tissue. In one instance Dr. Longaker made an incision in the median line. The tubes and ovaries were found free from pus, but of course congested. With the fingers within the abdomen he felt an abscess in the anterior pelvic wall. An incision was made over Poupart's ligament, as for ligation of the external iliac. Then passing deep into the pelvis, pus was reached some distance below the brim of the pelvis. In another case there was an indurated mass apparent above the left half of the pelvis, not recognizable through the vagina, except on very deep pressure. An incision was made above Poupart's ligament. After cutting through very dense tissue, he came to a minute cavity, which contained no pus, but a somewhat serous fluid containing flakes of lymph. These are only two of a considerable number of pelvic abscesses on which he had operated, and he had never regretted operating early.

DR. J. M. BALDY wished to take this opportunity of emphasizing views which he had expressed before the recent meeting of the American Gynaecological Society. He did not agree with Dr. Parish as to the pathology of this affection. He granted that there was the possibility of an abscess occurring in the pelvis, such as occurs in other parts of the body from the scalp to the foot, but held that these must be most rare. The gentlemen connected with what Dr.

Parvin had been pleased to call "the Philadelphia Dispensary School of Surgery," had now done over one hundred of these operations, and had not yet in a single case come across one which had not begun primarily in the tubes or ovaries. In every case the diseased mass removed has been tube, ovary and other tissues involved. (Dr. Parish, at this point, asked wherein his views differed from those of Dr. Baldy. Dr. Baldy said he would have to leave that to be judged from what Dr. Parish had said.) In regard to treatment he must again dissent from the views expressed. He thought that an absolute rule *could* be laid down. Where pus was found in the pelvis, early or late, the proper procedure was to open the abdominal cavity and remove the seat of the disease, where it was possible; and where it was not possible to remove, proper drainage should be established. However, it would be found comparatively seldom that the disease could not be taken out by a bold operator.

DR. JOSEPH PRICE thought that he understood Dr. Parish. He himself had said repeatedly that we might have an abscess in any part of the body from the scalp to the matrix of the nails; we may have it in the cellular tissue of the pelvis as well as in the axilla or neck; but he must hold to what he had said, that in all the pelvic abscesses that he had seen he had not found one not due primarily to tubal disease. Among the recent papers on the subject, one calls attention to the treatment by drainage through the vagina. He did not see how this would avail much in bilateral accumulations. Half of the tube may be evacuated, but a condition of affairs is left such as is found in an old bubo. In pelvic abscess we have just the condition of affairs which the surgeon is asked to treat in the groin, axilla or popliteal space. In such a case he would remove the disease by a clean enucleation and perfect a cure. He had not seen a case of pelvic abscess which could not be removed in this way, and he should say that such cases did not exist. One gentleman at Washington went so far as to say that after drainage by the vagina in a case of double pyosalpinx, recovery had followed—the woman had borne children. He might as well have said she had conceived, notwithstanding her husband had previously been castrated.

DR. M. PRICE remarked that it was doubtful if disease of the tube could be determined by simply looking at it. He remembered a case a few weeks ago, in which the

tube was congested and inflamed. It seemed to be simply swollen, but on pressure there was forced from the fimbriated end a drop or two of as perfect gonorrhoeal pus as could be found anywhere. If he had not seen the discharge, he should have thought that there was no disease save congestion.

DR. W. J. TAYLOR presented with the following remarks :

Three Uterine Myomata.

These three tumors were removed to-day from a case of considerable interest. The patient, a woman 30 years old, was married on 7th of last May. On the 20th she had her last menstruation and from that time considered herself pregnant. The abdomen began to swell, and she had a good deal of pain. A few days ago she sent for me and I found her with the abdomen much enlarged and presenting the symptoms of pregnancy. On the right side, however, there was a hard mass which puzzled me very much. She was seen by Drs. W. W. Keen and B. C. Hirst and the conclusion was reached that an operation was necessary. To-day abdominal section was made. It was found that the uterus contained a foetus, and that there were three fibroid tumors: the largest was sub-peritoneal, the smallest was attached by a small pedicle, and the second in size was also sub-peritoneal. These were removed and the patient is at present doing well.

DR. W. W. KEEN said that Dr. Taylor had hardly done himself justice in his modest narration of the steps of the operation and in his reference to the question of diagnosis. "When I saw the patient last Monday it was a question whether the large mass on the right side was a uterine myoma or a tubal pregnancy. It had grown rapidly and *pari passu* with the uterus. Two facts in favor of its being a solid tumor were its density and the fact that the pulsation of the aorta could be distinctly heard with the stethoscope at every point over the tumor. Its rapid growth seemed to be opposed to the idea of myoma. Dr. Hirst was of the opinion that it was a tubal pregnancy, at the same time recognizing an intra-uterine foetus also. She had albuminuria. When Dr. Taylor opened the abdomen two large tumors presented, which coalesced below but were separated above. Passing the hand into the abdomen the left tube and ovary were found normal. On the right side, it was at first not possible to recognize the ovary and tube, but by enlarging the incision the hand was passed

well down and the ovary and tube found. By the side of this tube was a vein considerably larger than my thumb. The pregnant uterus was recognized as the large tumor to the left. It was soft, elastic and dark in color. That to the right was recognized as a neoplasm. While I lifted with difficulty the upper end of the tumor, Dr. Taylor incised its capsule and enucleated it until he came to the attachment to the uterus, which was over a space of three or four inches in diameter, when the weight of the tumor then caused the uterine tissue to tear and the large sinuses began to bleed very freely. I next grasped the pedicle with the thumbs and forefingers of both hands while he stripped off the sac. The tumor was thus quickly removed and the uterine tissue and the wall of the sac were seized with large haemostatic forceps and the hemorrhage controlled. It was necessary at several points to introduce sutures into the uterine wall itself to control the bleeding. The redundant portion of the sac of the tumor was cut away and the edges brought together with the continuous cat-gut suture. A drainage-tube was passed down into its cavity. In at least two places and possibly four, there were upon the uterine wall small masses about half the size of my little finger nail. These looked like beginning malignant tumors. From the appearance and the rapidity of the growth, I think that this may be a sarcomatous tumor, though it is possibly a simple myoma."

DR. PARVIN thought that there was one point that even Dr. Keen had omitted. He saw the operation and the great mass of the tumor was included between the layers of the right broad ligament, so that the first incision was through the anterior layer of the ligament. Formerly, in removing a sub-peritoneal fibroid from the posterior surface of the uterus, the pedicle partly tore while the ligature was being applied, and there was free hemorrhage. He finally succeeded in stopping the bleeding by the use of the continuous cat-gut suture, after other measures had failed.

DR. HIRST said that Dr. Keen had correctly expressed his views. The symptoms pointed strongly to extra-uterine pregnancy. If the case had been allowed to go on to term, Cæsarean section would have been required, as the tumor filled up the pelvis. He had looked up this subject of injuries to the pregnant uterus and had found some interesting cases. In one case the woman was thrown to the ground and jumped upon when six months pregnant. The foetus was

killed but she went on to term. In another case trachelorrhaphy was performed during the second month of pregnancy. This case went on to term. In another instance a number of leeches were applied to the cervix of a pregnant uterus without any interruption to pregnancy. "In a case I had last spring, the woman was squeezed between a bale of goods and the wall and was seriously injured, but she went on to term. A German operator has such confidence in his ability to plunge a trocar into the uterus without doing harm that he advocates the occasional withdrawal by aspiration of the liquid in hydramnios with very great distension of the uterus, allowing the child to go on to term."

DR. PARISH said that the removal of ovarian tumors during pregnancy was recognized as a proper operation, but that the removal of uterine sub-peritoneal fibroid tumors during pregnancy was not regarded as a proper operation except under certain special circumstances. The injury necessarily inflicted on the uterus in their removal is liable to induce abortion. It would be interesting to have the further history of this case. The microscope alone could determine the character of this growth. Under ordinary circumstances the rapidity of the growth would point to sarcoma; but it is well known that in pregnancy fibroid tumors occasionally take on a rapid growth. He supposed that Dr. Hirst did not refer to the cases he had cited as indicating rules of practice. It must be the urgency of the condition which justifies operations on the pregnant uterus. While pregnancy may go on after injuries to the uterus there are numerous unreported cases in which the opposite has been the result. Where a sub-peritoneal tumor can be lifted from the pelvis, pregnancy may go on.

DR. J. PRICE thought that obstetrically the case was one of great importance. Some time ago he had called attention to three parallel cases. They all went to term with a pelvic tumor and died undelivered. The question of differential diagnosis scarcely concerned many operators at present; all that was required was the knowledge that there was a tumor present. We should never wait until the patient's general health has been impaired, as this is a departure from that generally followed in general surgery.

DR. HOFFMAN had been recently consulted by a woman who stated that she was pregnant and that at previous labors the baby "had to be mashed up." The pelvic cavity was found to be filled with a tumor.

She was advised to undergo an operation for its removal, but she refused. It seemed to him that there could be no doubt of the propriety of immediate operation in cases like the one before him.

DR. B. F. BAER believed that, in this case, after the exploratory incision had been made and it was found that no extra-uterine pregnancy existed, it would have been better to have closed the incision than to have removed the deeply located solid tumor; but since the removal was determined upon, he thought it would have been better to have amputated the uterus at the neck, than to have permitted it to remain with a great wound in its side and in the broad ligament. It is not likely that after such a serious operation the pregnancy will go on to term anyway, and abortion occurring within a short time after the operation will certainly add to the risks of the patient. He asked if there were any subjective signs of pregnancy (extra-uterine) in this case, such as the peculiar pains, uterine hemorrhage or discharge of decidua?

DR. KEEN thought that the removal of the uterus would have been a wholly unjustifiable procedure. It was possible that the woman might miscarry, but it was also possible that she would go to term. It has been shown that pregnancy is not necessarily a bar to operation. Not only would the sacrifice of the fetus have been unjustifiable, but hysterectomy would have made a young married woman sterile. The added dangers of a hysterectomy too might have turned the scale against the patient.

DR. B. F. BAER said that in regard to the removal of the uterus in this case, it seemed that Dr. Keen condemned the procedure because of his anxiety to save the child. He, however, believed that the child would have had a better chance for its life if nothing had been done. But if operative measures were imperative, then he still held to his former opinion. In answer to a question from Dr. M. Price, he said that he believed that hemorrhage may occur and the extra-uterine sac remain unruptured. He had seen a case which supported that view. The patient after missing her menses for two months, was one day seized with severe pain in the right iliac region, which was followed by shock. She fell in her yard, and when her physician arrived he found a condition of shock as well as hemorrhage. A few weeks after, she had a similar attack. He was then sent for and the diagnosis of extra-uterine pregnancy arrived at. This was five years ago, and Thomas's

method of operating by the vagina and opening the sac was followed. The sac was found with no evidence of rupture in it. The liquor amnii was clear and no evidence of hemorrhage into the cyst, which there would have been had a rupture taken place. The foetus was, indeed, alive. The patient died on the fifth day after operation.

Dr. WM. J. TAYLOR closed the discussion by saying that in this case the tumor was absolutely fixed. The woman's general condition was poor; the pulse 120; the patient unable to eat; she suffered intense pain and diarrhoea for a number of days before the operation. The tumor was also growing rapidly. The urgency of the case seemed to call for some relief. There was albuminuria. If the mother had been allowed to go on to term—provided the woman had lived that long—the risks to both mother and child would have been greater than they are at the present time.

FOREIGN CORRESPONDENCE.

LETTER FROM COLOGNE.

(FROM OUR SPECIAL CORRESPONDENT.)

The present century, which has often been named the era of inventions, might with equal propriety be termed the era of exhibitions and conventions. This would be especially true of Germany, for no people in the world exhibit a greater fondness for meetings, social or scientific, than do Germans. The medical profession in Germany has long recognized the great practical advantages and scientific value of frequent and unrestrained meetings. The annual convention of German physicians and naturalists, enjoying by special invitation the hospitality of a different city every year, is justly regarded as one of the most important meetings of German physicians. This year Cologne had the distinction of gathering within its ancient walls eminent medical men from near and far. At this meeting there were present Virchow, the pathologist, archæologist, and politician; Waldeyer, the foremost of German anatomists; Bardenheuer, Binswanger, Lassar, Weissmann, Meynert and a host of other physicians, many of whom are well known in America. Your correspondent counted the number of physicians present at over 800.

Binswanger, of Jena, read an admirable essay on *Crime and Mental Disorders*. The notions of good or bad, of health or disease, the speaker said, are not absolute and cannot be divided by distinct lines of demarcation.

The duty of a judge to test carefully the degree of the psychical liberty of a defendant becomes more and more evident. There are doubtless in our prisons persons with imperfectly developed mental capacities, in whom various inhibitory functions are disordered. There exists no doubt an innate and inherited moral defect which, with inexorable necessity, leads to crime. Judge and physician will readily agree in their decision where pronounced lunatic features are manifested by a criminal. But the distinction between a criminal lunatic and a demented criminal is often as difficult as it is important to make. Above all, we have to distinguish between the *occasional* and the *habitual* criminal, for the former is not subject to a permanent inhibitory influence of his mental powers. In this respect it will be necessary to examine in each instance the individual psychical development; in other words, to elucidate the biology of the criminal. There are psychiatric observers, such as Lombroso and Benedict, who believe that criminal tendencies are present in all persons, and that crime has a direct relation to the development of the brain and skull. But Binswanger emphatically repudiates such views, and ridicules both Lombroso's "criminal skull" and Benedict's "confluent criminal brain." A single symptom is, to the rational physician, never indicative of a certain affection, as it may be produced by various causes.

Virchow's lecture on *Artificial Deformities of the Body* was listened to with unusual interest. He thundered against the baneful influences exerted on the human body by various modern fashions. What is the use, Virchow asked, of introducing the principles and appliances of hygiene into the huts of the poor and ignorant, when the scions of wealth, pretended intelligence, and fashion, especially in the gentler sex, show their contempt of hygiene by their dress and general wearing apparel? In days gone by, the speaker said, I have battled against the diabolical invention called the corset; but this crusade has been given up by me as absolutely futile. The French shoe, with pointed toe and the heel under the middle of the foot, is another fashion which, on account of its detrimental influences on the body, cannot be opposed too energetically. Even the modern stocking, pointed and symmetrical, is injurious to health, as it does not conform to the anatomical formation of the foot. Virchow believes that the modern shoe and stocking, by weakening the toes, invite gouty deposits.

Waldeyer spoke upon *Women and the Study of Medicine*. He objected to the admission of women to the medical profession, and supported his objection by arguments which, however, though skillfully presented, can not all be regarded as sound. A woman, Waldeyer said, is a receptive and not a productive being. The ranks of medical practitioners, however, should consist solely of physicians who are individually able to further the interests and the development of the healing art. A woman cannot produce, and is also deficient in the art of combination. Her sphere is well defined by nature, and only by confining herself to the same may she hope to fulfill her mission and tasks. Experience has proved, he said, that a female medical student, though conscientious and diligent, is, in certain branches, distinctly awkward. In the chemical laboratory she is neither tidy (?) nor sharp, and greatly inconveniences the assistants by perpetual and unnecessary questions. An American woman physician has recently written a book, he said, but, as was to be expected of a woman, the production was a weak one (*sic*). Waldeyer eulogized the great tact and invaluable services of women nurses, but thought that the gentler sex should be admitted to the ranks of practitioners only in exceptional cases.

The exhibition connected with the meeting also presented many features of interest. Special mention should be made of a new inhaler constructed by Jahr, of the Imperial Health Board of Berlin. The advantages of this apparatus are: (1) it secures a more accurate dosage of medicines than has been hitherto feasible; (2) it prevents the condensation of too great quantities of the medicine in the mouth and throat; (3) it insures a longer and more energetic action of the medicine on the upper air-passages. The principle of the apparatus is based on the fact that medicine suspended in vapor which is of a higher temperature than the body is precipitated upon coming in contact with the respiratory passages, on account of the cooling of the vapor which then occurs. Another exhibit of interest was an aseptic pair of scissors. The peculiarity of the scissors consists in the absence of the joint, the scissors consisting of two blades which at the time of being used are easily joined like the two blades of a pair of forceps. The absence of the joint permits complete asepsis of the scissors.

Cologne,
Sept. 30, 1888.

PERISCOPE.

Diuretic Property of Preparations of Mercury.

The diuretic effect of the preparations of mercury has received thorough study from Dr. Wladyslaw Bieganski, who communicates a paper on the subject to the *Deutsches Archiv für klinische Medicin*, September, 1888. After referring to a previous paper by Dr. Jendrassik, whose results unfortunately remained inconclusive, he proceeds to give the results obtained in his own cases. The clinical value of the reports of his cases is much increased by the tables, which give the daily record of the medicine taken, the quantity of urine passed, its specific gravity, and remarks upon the condition of the patient resulting from the administration of the calomel. His first patient was a man 54 years old, who 25 years before had had syphilis. In the winter of 1885, he first noticed that his feet were swollen. After trying many domestic remedies in vain, he entered the hospital in August, 1886. It was there found that he had insufficiency of the tricuspid and of the aortic valves, with hypertrophy of the left and dilatation of the right heart. Both pleural cavities contained fluid, the exudate extending up to the eighth rib behind and to the fifth rib in front. There was also ascites and great oedema of the lower extremities. All the visible arteries were hard and tortuous, and the liver was enlarged and hard. Under treatment with calomel, in doses of forty-five grains a day, when necessary given with opium to prevent diarrhoea, the quantity of urine increased, the dyspnoea and oedema diminished, the latter disappearing entirely under the continued use of calomel. When the calomel was stopped, however, the symptoms reappeared, showing that the action of the drug was only temporary.

The second patient was also a man, and 67 years old, and affected for a long time with chronic bronchitis and emphysema of the lungs; he also had dilatation of the right ventricle, oedema, and ascites. Calomel was given as in the previous case, and the oedema disappeared, though more slowly than in the first case.

In the third case, a man 55 years old had chronic bronchitis with emphysema; dilatation of the right ventricle, consecutive insufficiency of the tricuspid valve; oedema and ascites. In this case the calomel failed to induce diuresis. The patient died, and at the autopsy amyloid degeneration of the kidneys was found.

The fourth patient was a young man 30 years old, who was known to have nephritis. There was marked oedema of the lower extremities, ascites, and a feeling of weakness. Calomel was given as in the other cases, but death resulted. No diuresis occurred, but rather a diminution in the quantity of the urine.

Bieganski devotes some time to determining the mode of action of calomel. At the outset he disputes the theory of Jendrássik, who maintained that calomel is absorbed into the blood as an albuminate and leads to a greater sucking up of fluids from the tissues, the fluids being immediately excreted by the kidneys. According to this view, the action of calomel would be like that of the diuretic salines. To determine the mode of action of calomel, Bieganski instituted experiments upon healthy people, employing in two cases calomel; in four inunctions of mercury, sometimes after calomel had been given and stopped, and sometimes from the first; in one case pills of corrosive sublimate, and in three cases injections of mercury, either of the black oxide or of corrosive sublimate.

His general conclusions are: 1. Calomel and other preparations of mercury act as diuretics, the quantity of urine excreted being at times very considerably increased. 2. For a few days after any of the mercurial preparations are given a diminution in the quantity of urine excreted generally occurs; this gives place to diuresis from the second to the tenth day. 3. The diuretic action is manifested best in oedema the result of heart failure. Pathological changes in the kidneys limit or entirely abolish the diuretic action. 4. Diuresis occurs just the same, whatever preparation of mercury and whichever method of prescribing is employed; but it is most marked after hypodermic injection, less after internal administration, and least after inunction. 5. The amount of the preparation is of most importance; small doses are not diuretic, this action being peculiar to moderate-sized and larger doses. 6. The quantity of urine excreted fluctuates, and these fluctuations may amount to twenty-four or thirty-six fluid ounces. The diminution and increase occur pretty uniformly every two days. 7. The diuretic action of mercury depends probably upon the irritation which the mercury during its excretion exercises upon the kidney substance.

In the same number of the *Deutsches Archiv*, Dr. R. Stintzing communicates a paper on clinical observations upon calomel

as a diuretic and hydragogue, from Von Ziemssen's clinic. He experimented with calomel upon twenty-seven patients with different affections, and concludes that it is the most energetic of all diuretics. It acts best, he says, in cardiac dropsy, either as the result of valvular lesions or of affections of the heart muscle. This action fails or is unsatisfactory if the insufficiency of the heart has reached the highest degree; but in that case other agents also are ineffective. In dropsy of other causes the calomel treatment is less applicable. In heart disease combined with chronic nephritis, calomel still comes into play if the nephritis is in the background as regards the heart disease. In the obviating of cardiac dropsy with calomel not only the increased diuresis but also the watery stools play an essential rôle. The freer the elimination by the former passage the greater the general result. Accompanying effects of the drug—salivation, stomatitis, diarrhoea, colic, etc.—may be checked by appropriate prophylaxis, or kept from doing injury in all cases in which polyuria is obtained. If the diuretic action does not occur, then symptoms of mercurial poisoning always occur. The best dose is that proposed by Jendrássik, three grains three times a day. The administration of it must be continued at least three days, but in special instances may be kept up with good result for twelve days. If the dropsy does not completely disappear, or if it returns, the calomel is to be repeated. Gargles of chlorate of potash should be used from the beginning as a prophylactic against mercurial stomatitis; and the calomel should be combined with opium. One-third of a grain of opium is sufficient generally for three grains of calomel. If stomatitis is severe and persistent diarrhoea occurs, the calomel is to be stopped at once. The quantity of urine begins to increase generally from the second or fourth day, rarely on the first or fifth day of the administration of the drug. Polyuria lasts in successful cases at least three days, generally four or five, in rare cases more, up to twelve days. The greatest quantity of urine passed in any of his cases was 8350 cubic centimetres (about nine quarts). Digitalis and other diuretics act as diuretics less powerfully than calomel; but calomel cannot substitute them, for it is no cardiant.

—In the *Lancet*, October 13, 1888, Mr. Frederick Treves reports a case of intestinal obstruction due to a very rare cause—hernia into the foramen of Winslow.

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**MEDICAL AND SURGICAL
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 ISSUED EVERY SATURDAY.

CHARLES W. DULLES, M.D., EDITOR.

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Write in ink.

Write on one side of paper only.

Write on paper large letter size.

Make as few paragraphs as possible. Punctuate carefully. Do not abbreviate, or omit words like "the," and "a" or "an."

Make communications as short as possible.

NEVER ROLL A MANUSCRIPT! Try to get an envelope or wrapper which will fit it.

When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.

The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

RECOVERY FROM HYDROPHOBIA.

A pleasing variation from the usual reports of cases of hydrophobia comes, under date of September 24, from St. Louis. According to the newspaper reports, a boy, fourteen years old, had developed what are often considered to be the symptoms of hydrophobia. He is said to have barked and frothed at the mouth, and to have gnawed at the carpets and chairs. Physicians being summoned to his assistance, it is said that they confirmed the popular diagnosis of hydrophobia, and instituted the customary plan of treatment, the boy being held by strong men and fastened to his bed, and the usual prognosis of death being given. In this case, however, fortunately for the lad, he disappointed the expectations of those who watched over him, and after a short period of unconsciousness, during

which he was probably free from the kindly but unwise ministrations to which he had been previously subjected, he revived, and manifested no further symptoms of this dread disorder.

The evidence that this boy had genuine hydrophobia is not to be dismissed as entirely unworthy of belief; for the reason that it is quite as complete and quite as well authenticated as in the great majority of cases in which death follows instead of recovery. It is true the amount of evidence is not very great to the scientific mind, but it would be sufficient, we think, to convince Monsieur Pasteur, if we are to judge by the history of some of the cases to which he has applied his method of preventive inoculations.

The most suggestive part of this story, in our opinion, is that which states that the boy's recovery followed promptly upon the period in which he was not subject to any medicinal or mechanical treatment. And, to be entirely serious, we believe that this, which is in accord with some of the most scientific observations on the treatment of tetanus in horses, indicates in the present state of knowledge—as opposed to prejudice—in regard to hydrophobia, a part of the treatment which, whatever else may be done, is absolutely essential to the proper management of these trying and terrible cases.

THE ABUSE OF CHEMICAL ANALYSIS.

The rapid multiplication of real or pretended chemical analysts of late years, and the keen competition of manufacturers of pharmaceutical and food preparations, have brought about a state of affairs which may prove somewhat perplexing to the medical practitioner who desires to advise his patients intelligently in regard to their medicines, their foods—and, perhaps, their drinks. It has become the fashion to spread before him what purport to be exact statements as to the ingredients of various articles recommended to his notice—a fashion which is to be commended whenever it is honestly

followed, and which, under these circumstances, brings the manufacturer into the best possible relation to the practitioner of medicine. But, unfortunately, what might, if rightly used, be of the greatest service to physicians has proved so powerful an assistant to commercial ventures that it has come to be abused and prostituted to utterly unworthy purposes. Thus, the advertising pages of medical journals, and, in some regrettable cases, their reading pages, often present reports of so-called analyses which have been framed, not to instruct but to deceive those to whom they were addressed. On the other hand, honest and faithful analyses have been garbled, or parts of them have been picked out and used to advertise articles which the analysts themselves had no idea of recommending.

Examples of this practice have been furnished of late in different parts of the United States. In this city a well-known chemist has recently found it necessary to disclaim responsibility for the way in which his report as to the presence or absence of salicylic acid in certain specimens of beer has been used by the manufacturer of one of them as a certificate of its absolute purity. In other cities we have had flagrant examples of analyses which seemed to show that articles suspected or asserted to contain dangerous ingredients were free from them; and analytical testimonials to the worth of medical and sanitary preparations seem to have become in some places a regular article of commerce.

For these reasons chemical analyses have lost the credit which they once had, and which they ought to have, with physicians. But, besides this, they have proved injurious in some cases to the manufacturers themselves; for, with the advent of reports which misrepresented certain medicinal and food preparations in the interests of those who sold them, there have come reports which misrepresented them quite against these interests. A recent example of this is found in the history of a much-used food-

preparation, the manufacturers of which have been prompted to collect and publish evidence to show that a chemist whose name is familiar to all readers of the advertisements in medical journals has made a report in regard to the ingredients of this food which is marked by prejudice or stupidity.

Some of this evidence has been published in certain medical journals which had before given publicity to the adverse report, and its absence from the columns of the *REPORTER* is due only to the fact that we have not admitted anything to them which seemed to bear plainly the mark of commercial controversy. The inflexible rule of the *REPORTER* is to restrict advertisers to the advertising pages; and, as we have steadily refused to publish in our reading pages laudatory notices of commercial articles, neither will we admit to them criticisms prompted solely by business competition. When actual fraud has been proved, or when it has been shown to be highly probable, we have not hesitated to express our opinion; but we have not taken part in controversies about commercial preparations for any less serious cause.

In regard to much that passes for chemical analysis we feel that our knowledge is not sufficient to enable us to give a judicial opinion; and, until we feel more confidence than we do now in our judgment on such matters, we must confine those who contest about them to our advertising pages, and restrict our own utterances to such general statements of principle as may aid the readers of the *REPORTER* in arriving at just conclusions.

At present our purpose is to call attention to the abuse of chemical analysis which is bringing discredit upon a method of advertisement which might be of the greatest service to our fellow-practitioners, and of the greatest advantage to honest manufacturers. The first step toward the correction of this abuse is to point it out; and we trust the succeeding steps will appear before long.

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BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

THEINE IN THE TREATMENT OF NEURALGIA. By THOMAS J. MAYS, M.D., Professor of Diseases of the Chest in the Philadelphia Polyclinic, etc. 16mo, pp. 84. Philadelphia: P. Blakiston, Son & Co., 1888. Price, 50 cents.

This little book contains an essay on Theine already published in the *Polyclinic* during the latter part of 1887 and the beginning of 1888. Dr. Mays has made a very thorough study of this drug, both physiologically and therapeutically, and has demonstrated its value as a remedial agent in the treatment of various forms of neuralgia. It is our impression that the results of his study are not as well known as they ought to be, and we strongly recommend our readers to get a copy of this cheap and valuable monograph, and learn what theine actually is and what service it may render them in their practice.

CORRECTION.

By an error in the review of Dr. Howe's book on "Excessive Venery, Masturbation, and Continence" (*REPORTER*, Sept. 29, p. 413), the publishers were stated to be J. H. Vail & Co., instead of E. B. Treat, New York.



PAMPHLET NOTICES.

[Any reader of the *REPORTER* who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request stating where the notice was seen and enclosing a postage stamp.]

THE THERAPEUTICS OF DIPHTHERIA. By A. JACOBI, M.D., New York. From the *Transactions of the Philadelphia County Medical Society*, May 23, 1888. 23 pages.

CONSERVATISM IN GYNAECOLOGY. By A. REEVES JACKSON, M.D., Chicago, Ill. From the *Chicago Journal and Examiner*. 7 pages.

THE EARLY DIAGNOSIS OF SPINAL CAVIES, WITH REMARKS ON TREATMENT. By HUNTER P. COOPER, M.D., Atlanta, Ga. From the *Atlanta Medical and Surgical Journal*. 10 pages.

THE TREATMENT OF HEMORRHOIDS. By HUNTER P. COOPER, M.D., Atlanta, Ga. 9 pages.

SOME RETROSPECTIVE AND PROSPECTIVE THOUGHTS ON SURGERY. By DONALD MACLEAN, M.D., Detroit, Mich. From the *Journal of the American Medical Association*, June 30, 1888. 33 pages.

CRIMINAL ABORTION, OR FETICIDE. By H. C. GHENT, M.D., Belton, Texas. From the *Transactions of the Texas State Medical Association*, 1888. 28 pages.

RELATION OF DISEASES OF THE KIDNEY, ESPECIALLY BRIGHT'S DISEASE, TO DISEASES OF THE HEART. By J. M. DACOSTA, M.D., Philadelphia. From the *Medical News*, May 5, 1888. 37 pages.

—As the whole of Dr. Jacobi's paper was laid before the readers of the *REPORTER* in our issues of June 23 and 30, 1888, it is not necessary to speak in detail of this reprint. But we can recommend its careful perusal to all who have not already read it in the pages of this journal, as the expression of the opinions of one who is justly celebrated for his study of this interesting subject.

—The substance of this pamphlet was published

in the *REPORTER*, June 9, 1888, in our report of the proceedings of the Illinois State Medical Society in May of this year. It contains a strong protest against the too frequent performance of abdominal section upon women, and denounces those whom the author suspects of operating more for their own glory than for the good of their patients, in most unqualified terms.

—Dr. Cooper's paper is chiefly devoted to emphasizing the importance of an early diagnosis of Pott's disease, and describing the way in which this diagnosis is to be made. This part of his paper is both interesting and instructive, while the part devoted to describing the treatment of caries of the spine is as brief as it is clear. Dr. Cooper recommends the use of the plaster-of-Paris jacket as "the easiest, cheapest and best treatment in the vast majority of cases."

—In this paper, which was read before the Medical Association of Georgia, April, 1888, Dr. Cooper very sensibly remarks that "a surgeon in general practice will obtain far better results if he thoroughly familiarizes himself with the details of two or three operations than he will by attempting to perform all of the dozen or more which have been recommended." His pamphlet contains a brief and succinct account of the different varieties of hemorrhoids, and describes three methods of operating for their relief: dilatation of the anus, injection of carbolic acid, and the ligature. The opinions of Dr. Cooper are the more interesting, in that his experience leads him to dissent from some of the views expressed by other surgeons. His paper is so instructive that it may well be recommended to the attention of our readers.

—Among the interesting features of Dr. Maclean's address before the Surgical Section, at the last meeting of the American Medical Association, is his defense of chloroform as an anaesthetic, which he has employed for thirty years, without an accident which could in any way be attributed to its use. His whole address covers a number of points of great importance in the practice of surgery, and is of the greatest value as expressing the mature opinions of a surgeon of unusual skill and judgment.

—Dr. Ghent has taken the pains to collect the opinions of a number of well-known medical men in regard to the frequency of criminal abortion in the United States, its causes, and the means for its prevention. To these are added, in the pamphlet before us, his own views as to the enormity of this crime and the duty of the medical profession in regard to it. As might be expected, he lays the greatest stress upon the right of the fetus to life and care, and urges his professional brethren to use their best endeavors to promote correct views in regard to this matter among the persons who come under their influence.

—Dr. DaCosta's Middleton Goldsmith Lecture, delivered before the New York Pathological Society, April 18, 1888, contains a learned defense of his opinion that the "cardiac hypertrophy which is found in Bright's disease is not in any sense the consequence of that disease," and that it is in the nervous system that we must search for the original source of the malady, which includes both heart and kidney in its ravages. The vast experience and careful investigations of Dr. DaCosta lend great weight to anything he says, and his views on the important subject discussed in this address deserve the most careful attention of all pathologists and practising physicians.

CORRESPONDENCE.

A Statement from Dr. Willard H. Morse.

To THE EDITOR.

Sir: I ask the favor of being permitted to answer with my side of the story, the editorial which appeared in your last issue concerning myself.

Although I am but a young country physician, in indifferent health, and without the facilities at the hands of many others, I have, during the eight years since my graduation from the Albany Medical College, engaged more or less largely in the study of new remedies, and in practical chemical work. It is true that instead of a large botanical garden, I have only a little plot of land, and instead of an extensive laboratory, only an office room with the necessary working apparatus. But I have worked as I could, writing the treatise "*New Therapeutical Agents*" (1882), and some sixty papers for the medical press. I do not boast of this, or of chemical labors, as what I have done speaks for itself.

You will remember that in the REPORTER for Nov. 26, 1887, I had a paper on "Gleditschine," which I think had a little to do with the exposure of that "alkaloid." At least it brought me a deal of prestige; and last spring, in looking for another like "foe to conquer," I had my attention attracted to the Scotch Oats Essence, which the *Druggists Circular* and *Boston Journal of Health* had stated to be base with opium and alcohol. It occurred to me that it would be a good idea to analyze the preparation and expose its character a little more fully than had been done. But on examining the bottle obtained for the purpose, I was surprised to find that it did not contain opium, although there was some alcohol present. I thought this strange, and proceeded to investigate the source of the charge. Finding the *Journal of Health* to be anonymously edited, and with its "chemist" acting under an assumed name, I concluded that the source was hardly creditable, and stated my findings (May 1). Soon after, I was advised by Dr. R. G. Eccles, now president of the State Pharmaceutical Society, and others, that I must have examined a bottle put out since April 18, since which time it was alleged that the preparation had been changed in quality, and the opium left out. This fact was not known to me, and I took immediate opportunity to purchase bottles of both the

"guaranteed" and "non-guaranteed" articles, and to conduct a careful examination of both, according to advice of Dr. Eccles, and by a method of his prescription. The result was that I found that it was the "guaranteed" article which I had first examined. On May 31, I wrote Dr. Eccles as follows:

"The results in corroboration show that the bottle first examined must have been one bearing the forfeit label."

Shortly afterward I wrote an article on the matter, but for reasons not deemed judicious, it was not published.

The *Druggists Circular* seems to have come to the conclusion—and a very natural one, too—that I was retained by, or interested in the Essence, in some way; and forthwith began its attack. On learning this, I addressed the editors the statement given above, and sent it to them through my pastor, Rev. J. A. Owen. To it I added—and I reiterate it now—that I have never met anyone connected with the manufacture of the preparation, and that my action was wholly voluntary, and uninfluenced by such parties. The outcome had meanwhile transpired.

The work done as a therapeutist had brought my name before the public, so that I have gradually come to do considerable work as a chemist. My reports I have sought to make thorough and careful; and to this end I have sent a copy to the manufacturer that he might suggest any corrections, other than chemical. As my reports are sometimes used for advertising purposes, it has been my custom sometimes to state that the copy can be retained for \$10, if desired, thus avoiding needless correspondence.

On May 5, I think, I had occasion to examine Laviolette's "Oil of Florida Water," to find whether his claim that it "makes a water equal to Murray & Luman's," was tenable. On July 5, after careful research, I certified in favor of the claim, and sent Laviolette a copy. He returned answer that he thought my report might have "made a better showing." In answer I invited his advice, and soon after, he sent me his "special sample" (so styled by him). This sample was unsolicited. On opening it, I remarked its peculiar smell, but while exhibiting the vial to my wife, it was accidentally broken. A few drops which remained I found to be Oil of Bay, an article which Laviolette stated in court, "anyone could distinguish from Oil of Florida Water." My first estimate

being thorough, and considering that the man merely wanted something more elaborately worded, I, that same night, wrote out a second report. No statement was made that the report was on the second sample; for in the first place anyone knows that an "elaborate" analysis cannot be made in five hours; in the second place, having been thorough at first, I could not subsequently be more so; and in the third place, I inferred that a mistake had been made, and the wrong oil sent me. If my first report had not seemed to him "full" enough, he should have instructed me to obtain another bottle in the open market, and not have sought to make me amenable to law by certifying supplementarily on a proffered sample. This alone was enough to arouse suspicions of the man's purpose, but I did not expect that he would think anyone (even a barber) such a fool as not to be able to distinguish the two oils, the one from the other! The trial developed the fact that the *Druggists Circular* had instigated the whole proceeding. The hearing also showed that though a strong attempt was made to get me to commit a crime, there was not evidence enough to show that it was committed.

In writing you to ask that you state the matter, I quoted you the statement of the *Tribune* to the effect that the prosecutors were satisfied as to the justice of the acquittal, a statement which I supposed veracious, as coming from such a paper.

I may be something of a "crank," but at the same time I profess to be a chemist and therapist. I deny most emphatically having ever certified by "influence," or to that which research would not bear out. I have worked for eight years, without pretensions, with care, and in love with my work; and (D. V.) I shall continue my labors in my humble way, and according to the best of my ability. I feel no shame, and have no compunctions of conscience. I regret that I have to ask to occupy so much of your space; and thanking you for your past confidence in me, I trust to be able to merit its continuance.

WILLARD H. MORSE, M.D.

Westfield, N. J.,
Oct. 16, 1888.

[We think it only fair to permit Dr. Morse to reply in our columns to the comments on his case published in our issue of October 13. We have nothing to add to what we have said, and what he now says, except that we have no pleasure in expressing censure, and that we sincerely hope he may merit and secure the good opinion of right-minded men.—Editor of the REPORTER.]

Electrolysis for Stricture of the Urethra; Death.

To THE EDITOR.

Sir: I have had a case of suppression of urine and death following electrolysis for stricture, which I wish to report. The case so closely resembled an attack of pernicious ague—"sinking chills"—that I would like to hear comments upon it from yourself or some of your readers.

On the 20th of August, 1888, I saw the patient in consultation with a physician of a neighboring town. The patient was 56 years old, a cattle-breeder and importer doing an extensive business. Ten years ago he contracted an inflammation of the urethra, whether specific or not those of us who saw and treated it were undecided. The canal had a dry, red appearance, with very little if any suppuration. It would readily yield to treatment and apparently get well. But a glass or two of beer or whiskey, or any over-exertion, would start it up again.

It did not seem to be communicable. His business required much traveling, and he was treated for it in various parts of this country and Europe, always by the best practitioners obtainable under the circumstances, he never trusting himself in the hands of the so-called specialist who infests all our larger cities. After six or seven years he noticed that his stream of urine was becoming smaller. While in the mountains of the West last summer the symptoms of stricture became very annoying.

I found the meatus corresponding to No. 5 American scale, with the normal urethra behind it measuring 15. The meatus was incised and a No. 12 sound was passed, and encountered a stricture just behind the bulb. The patient showing signs of shock, no attempt was made to pass a sound any farther. It was agreed that his attendant should keep the meatus patulous by passing through it a test-tube, No. 15 in size, and when the incision was sufficiently healed send him to my office for electrolysis.

On the 31st of August he presented himself, saying that he had had the ague on the 29th—two days before. I found that a No. 2 Tiemann bulbous rubber bougie was the largest that could be passed into the bladder. Using my smaller olive, a No. 11 English, it was passed down to the stricture and connected with 12 Law cells, which were slowly increased to 20. (They were not very active, not having been charged for 2 years.) The bougie passed through this stricture in seven minutes, encountering another three-quarters of an inch beyond.

The latter was passed in the same length of time. The olive was then withdrawn above the first, and passed through them again, taking four minutes' time. Shock was very slight, only a little pallor; the pain was insignificant.

He left my office immediately and rode twenty-four miles on a train, feeling no inconvenience except scalding on urinating. After attending to some business, instead of staying in town as he was expected to, he mounted a road-cart to ride three miles into the country. While on the road he was taken with a very severe chill and sudden prostration. When his physician reached him he had the appearance of profound shock: vomiting, cold extremities, clammy perspiration, pulse scarcely perceptible and only forty per minute. He passed two ounces of bloody urine. By energetic treatment a partial reaction was brought about. The temperature in the mouth for a short time was above normal, but did not remain so more than an hour.

I saw him at 5 P. M. Sept. 1. His temperature was then 96°; pulse 84, very weak, and easily compressed. Respiration 24 and jerky. The stomach was irritable, the bowels constipated. He was given strychnia, strophanthus, atropia and whiskey hypodermically; whiskey, digitalis, tincture of cantharidis, sulphate of quinine, in a pint of hot water by the rectum. The latter was repeated five or six times in fifteen hours. The hot water was all retained and apparently absorbed. Calomel and bismuth were given by the mouth. Dry cups were placed over the kidneys and artificial heat applied. Nothing, however, did any good. He gradually sank and died at 4 P. M. Sept. 2. Two hours before death a catheter was introduced and half an ounce of bloody urine withdrawn.

Now, how much did the electrolysis have to do with the fatal result? The case closely resembled in its symptoms the "congestive chills" we used to encounter in this vicinity over thirty years ago.

A. ADV, M.D.

Muscatine, Iowa,
Sept. 20, 1888.

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—Dr. J. J. Leppa, says the *Medical Record*, October 20, 1888, has been sued for malpractice by an Italian woman to whose son he had given chloroform and ether for eclampsia. The anaesthetics controlled the convulsions, but the boy died.

NOTES AND COMMENTS.

Antipyrine in the Pain of Dysmenorrhœa.

Dr. Windelschmid states in the *Allgemeine med. Central-Zeitung*, No. 53, 1888, that the sedative action of this agent has given brilliant results in the pain of dysmenorrhœa. He prescribes it in doses of 30 grains in clyster before and during menstruation. Generally its action was manifest after one-quarter of an hour, but in one case it had to be repeated in twelve hours. Its action was strikingly favorable, especially in two cases, in which all the resources of gynecology, both external and internal, had been exhausted in vain. These patients for eight days, before and during the period, suffered with violent pains and cramps. Clysters were used in the morning and evening, and in the following evening. Generally the analgesic action, even in children, was associated with a narcotic effect. Disagreeable complications, with the exception of profuse sweats and often slight retention of urine, were not observed. A glass of wine or beer was often given to prevent collapse. Urticaria was observed in the case of a boy seven years old, who had been given four and one-half grains of antipyrine by the mouth. It was accompanied with high fever, and lasted about twelve hours.

Union by First Intention of Wounds Exposed to the Air.

A correspondent of the *Medical Press and Circular*, August 1, 1888, reports from Paris that M. Léon le Fort had recently attacked the method of Lister, which he taxed with exaggeration. According to the English surgeon, the air contained germs which excited suppuration, and in order to destroy these ferments, phenic acid was used under every conceivable form. Reunion by first intention was sought, in order to prevent the suppuration. His doctrine (M. le Fort's) attributes no evil influence to the air in the propagation of purulent infection, but to the fingers, instruments, and sponges used in operations. He applied himself to prove that air was innocuous, and for that purpose left all his wounds from operations, some of which were major, exposed to the air during the whole course of the operation and for some time afterward. Reunion by first intention always took place, and without suppuration.

Formulae for Creasote.

Dr. Keferstein gives some formulae in the *Therapeutische Monatshefte*, September, 1888, which have proved useful in his practice. The following formula, he says, gives a clear mixture which tastes and smells decidedly better, and is also cheaper, than the formula suggested by Bouchardat, which contains Malaga wine:

R. Creasot	m _{xx}
Spir. vini rectificat.	f ₃ vi ₁ / ₂
Aq. cinnamomi	f ₃ iiiss
Syr. cinnamomi	f ₃ vi ₁ / ₂
M. Sig. A tablespoonful three times a day, increasing one tablespoonful weekly.	

The following formula is for administration of the creasote in pill-form:

R. Creasote	3 i
Powd. althea root	3 iss
Licorice juice	f ₃ iss
Mucilage of acacia, q. s. ut fiant pil.	
No. 120; coat with gelatine.	
Sig. Six pills three times a day.	

When there is much cough and diarrhoea, the following may be given:

R. Creasote	gr. xv
Acetate of lead,	
Opium (pure)	aa gr. ivss
Licorice juice	f ₃ iss
Mucilage of acacia, q. s. ut fiant pil. No. 50.	
Sig. Five pills three times a day.	

Five pills contain one and one-half minims of creasote.

Instead of giving the creasote in cod-liver oil, Keferstein has the following emulsion made, which can be taken even by children:

R. Creasot	m _{xx}
Solve in	
Olei amygdalæ	f ₃ viiss
Pulv. acacie	3 v
Aq. destil.	f ₃ iiiss
M. ft. emulsio. Adde	
Tinct. aurant. comp.	m _{xv}
Elaeosach. menth. pip.	f ₃ i
M. Sig. A tablespoonful from two to five times a day.	

In the case of children it will be sufficient to make up half the quantity, and give a teaspoonful of it at a time. One tablespoonful of this emulsion contains one and one-half minims of creasote. If the taste of oil is detected, black coffee may be given after it.

The following formula is suitable for giving creasote in the form of drops:

R. Creasoti	m _{xl}
Tinct. cinnamomi	f ₃ viiss
M. Sig. Fifty drops three times a day, or one-half teaspoonful in a cup of warm milk, added while the milk is vigorously stirred.	

Twenty-five drops of this mixture con-

tain one and one-half minims of creasote. Instead of milk, wine or warm sugar and water may be used; but if alcoholic fluids are used they should be cold, while if non-alcoholic fluids are used—the best of which are mucilaginous—they should be warm.—*Wiener med. Presse*, September 30, 1888.

Antipyrine in Chordæ.

Archibald Dixon, of Henderson, Ky., writes to the *Weekly Med. Review*, July 4, 1888, that he has found antipyrine of use in chordæ. Given in doses of fifteen to twenty grains, in a wineglassful of water, just before retiring, he says it has effectually relieved all symptoms in three cases. In only one case was it necessary to repeat the dose during the night. He suggests for it a further trial.

Lectures at the Polyclinic.

The second annual series (Part I) of Evening Lectures on Practical Subjects will be given by the Faculty of the Philadelphia Polyclinic, at the College Building, Broad and Lombard Streets, free to members of the profession and medical students, and in the following order. The lectures begin at 8 o'clock.

Oct. 23, Prof. Henry Leffmann: "The Recognition of Poisoning."

Oct. 30 and Nov. 6, Prof. Thos. J. Mays: "Pulmonary Consumption considered as a Neurosis."

Nov. 13, Prof. Charles K. Mills: "Visual Localization."

Nov. 20, Prof. J. Henry C. Simes: "Pseudo-Sexual Disorders."

Nov. 27, Prof. S. Solis-Cohen: "The Management of Fever, with Especial Reference to High Temperature."

Dec. 4, Prof. H. Augustus Wilson: "The Preparation and Application of the Plaster-of-Paris Bandage."

Dec. 11, Prof. John B. Roberts: "Treatment of Leg Ulcers."

Dec. 18, Prof. Edward Jackson: "Failure of Sight in Old People."

Jan. 8, Prof. Chas. H. Burnett: "Some Common Causes of Deafness: Prevention and Cure of the Disease."

Jan. 15, Prof. Alexander W. MacCoy: "Observations on Certain Forms of Hoarseness."

Jan. 22 and 29, Prof. Benjamin F. Baer: "Pelvic Inflammation: Its Causes, Complications and Treatment."

Part II will be announced hereafter.

NEWS.

—The quarantine station for Philadelphia will be closed Oct. 31.

—Professor G. Ruge, of Heidelberg, has been appointed Professor of Anatomy.

—Diphtheria is epidemic in Athens, Ohio. The public schools have been closed on account of it.

—Bellevue Hospital, New York, is to have a chapel and library. The new building is now going up.

—Dr. Ferdinand E. Chatard, of Baltimore, died October 18, 1888. He was graduated from the University of Maryland in 1861.

—In a communication in the *N. Y. Medical Journal*, October 20, 1888, Dr. F. Whitehill Hinkel reports upon the use of antipyrine in acute coryza, frequent bleeding from the nose, and in hay fever.

—The *Engineering and Building Record*, October 20, 1888, protests against the pollution by sewage of the Passaic River water which is supplied to Jersey City, and declares that the water is likely to grow worse instead of better.

—The Trustees of the Hoagland Laboratory, Brooklyn, N. Y., announce that it is now open for students who desire to make original researches. Instruction in Bacteriology will be given during the winter and spring by Dr. George M. Sternberg and Dr. George T. Kemp. The fee is fifteen dollars, "which will entitle the subscriber to prosecute his studies until June 1, 1889, during as many hours of the day as he may desire."

—The *New York Sun* says: If doctors' signs are any indication of disease, the new West Side must be one of the unhealthiest parts of the city. There is a doctor's sign on every large apartment building, and they average about one sign to every five or ten private houses. The real secret of their frequency is not that there is business in that part of the city for all the doctors or for one-quarter of them, but that the recent rapid development of that section has led scores of young doctors to go there to grow up with the community in the hope of some day getting together practice enough to live. About one in a dozen of the earliest comers really did find a practice growing up around him, and a few of the West Side doctors therefore are getting rich fast, but for the rest they come, stay a few months, or as long as their capital lasts, waiting for the practice that never comes, and then they

drift away; but other raw recruits from the colleges take their places and more, so that while the signs change too frequently for the neighbors to keep track of them, their number never decreases.

HUMOR.

HE HAD BOTH KINDS.—Old lady (to druggist's boy)—"I want to git a leetle paint, boy." Boy—"Yes'um; face or fence?"—*Life*.

FRIEND (to Congressman's wife)—"Is your husband a man of sedentary habits?" Wife—"Of course not. He hasn't touched a drop in 15 years."—*Washington Hatchet*.

SHOULD YOU UPSET A BOTTLE OF CASTOR oil on the carpet the best treatment for removing the spot is to place the bed over it. This is both cheap and efficacious.—*Ledger*.

TERRIBLY BROKEN.—"And are you really so badly broke, my friend?" he said, as he tendered the tramp a penny. "Broke?" was the bitter response. "I'm as badly broke as the Ten Commandments."—*Life*.

INVALID—"I have been here at these springs, doctor, six weeks, and I don't see that the water has had the slightest effect." Dr. Candid—"You must have patience. There was a man here last season who didn't die until after he had been here two months."—*Texas Siftings*.

A WISE PRECAUTION.—Brown—"What have you got in the bottle, Robinson?" Robinson—"Ether." Brown—"What are you going to do with ether?" Robinson—"That big duffer Jones has threatened to whip me on sight; and as soon as I see him coming, I'm going to take it. I don't propose to suffer if I can help it."—*Puck*.

OBITUARY.

JOSEPH WARRINGTON, M.D.

Dr. Joseph Warrington, whose death was announced in the REPORTER Oct. 20, died at Moorestown, N. J., at the advanced age of eighty-three years. He was a famous physician years ago before he gave up active work. He was graduated from the University of Pennsylvania in 1828, and began the practice of medicine in Pennsylvania, continuing in practice until 1854, when he retired to his farm near Moorestown. He was one of the founders of the Philadelphia County Medical Society and the State Medical Society of Pennsylvania, and of the Philadelphia Lying-in Charity.